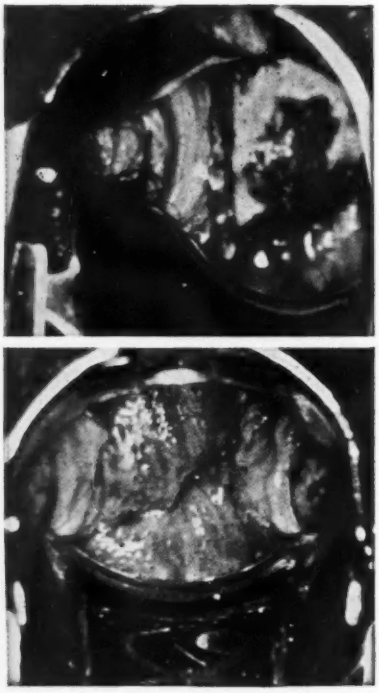
MEDICAL WORLD NEWS

SEPTEMBER 1, 1961

SPOTTING BRAIN LESIONS

First Clearance on
Oral Polio Vaccine

To Tell or Not to Tell—
A Legal Dilemma for MDs



monilial vaginitis

A COMMON PROBLEM INCREASING YEAR BY YEAR[1]

Candidiasis is especially serious in diabetics... during pregnancy...in the debilitated...and when broad spectrum antibiotics have been administered in high dosage, with or without concurrent administration of cortisone or related steroids.

Clinical Results: In 26 patients (11 pregnant) with vaginal moniliasis, treatment with Mycostatin Vaginal Tablets was completely successful in 92% of cases. Marked to moderate improvement was shown in the remainder.[2]

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Supplied: Each Mycostatin Vaginal Tablet—individually foil wrapped, contains Mycostatin, 100,000 units, and lactose, 0.93 Gm. Packages of 15 with applicator. Also available: Mycostatin Oral Tablets...Ointment...Dusting Powder...Powder for Suspension...Cream.

References: 1. Lee, A. F., and Keifer, W. S.: Northwest Med. *53*:1227 (Dec.) 1954. 2. Caruso, L. J.: New York J. Med. *58*:1688 (May 15) 1958. 3. Pace, H. R., and Schantz, S. I.: J.A.M.A. *162*:268 (Sept. 22) 1956.

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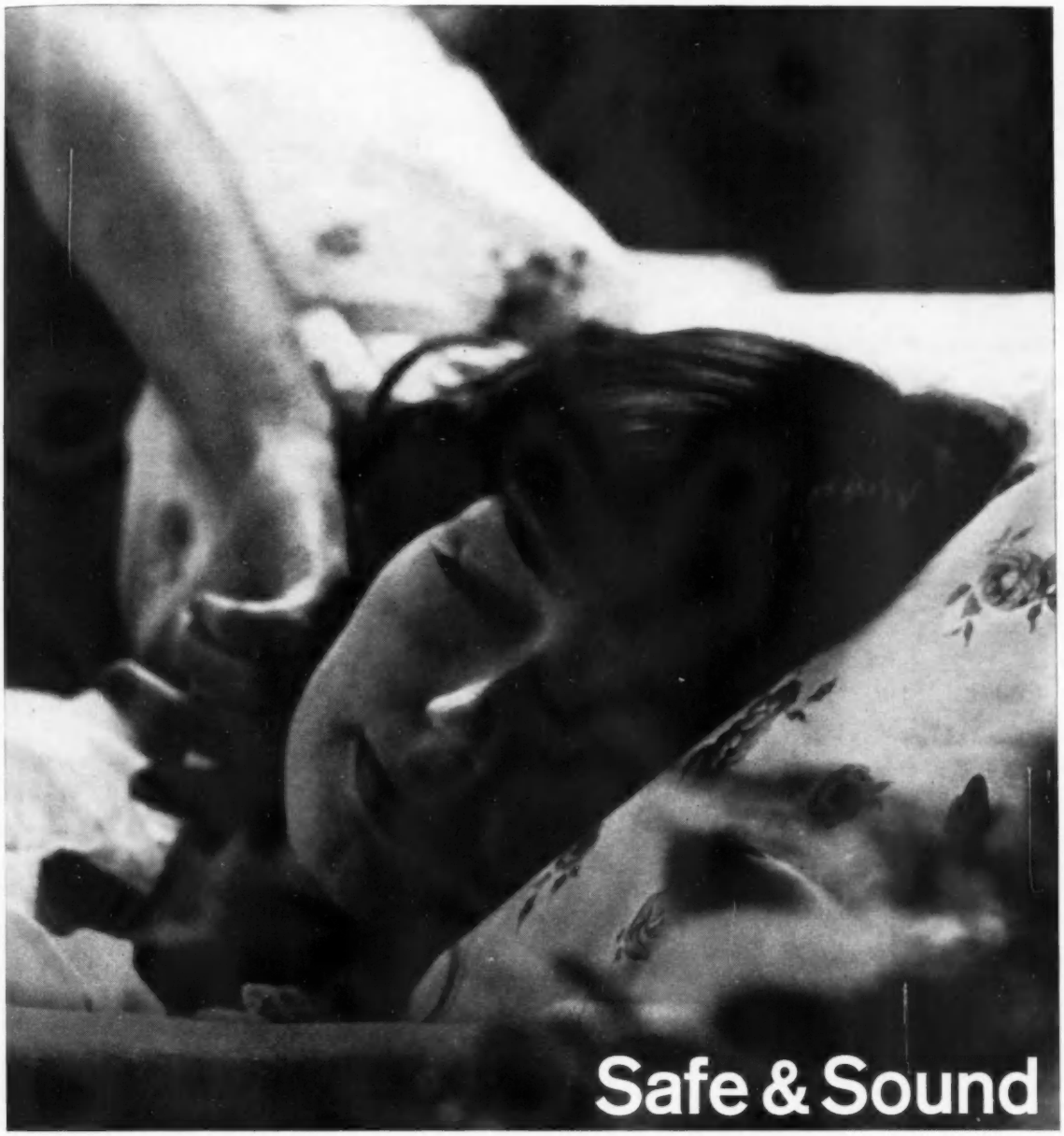

Sleep is sound, sleep is secure with Doriden. Five years' clinical experience has proved its efficacy and wide margin of safety, has made it the most widely prescribed nonbarbiturate sedative. The clinical safety of Doriden—in terms of minimal side effects,[1,2] absence of respiratory depression,[1-4] and lack of adverse effects on liver,[5] kidney,[1,5] and blood—has been confirmed repeatedly. So, for *all* the benefits of safe and sound sleep—prescribe Doriden.

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Doriden Capsules

Supplied: *Capsules*, 0.5 Gm. (blue and white). *Tablets*, 0.5 Gm. (white, scored), 0.25 Gm. (white, scored) and 0.125 Gm. (white).

References: 1. Blumberg, N., Everts, E. A., and Goracci, A. F.: Pennsylvania M. J. *59*:808 (July) 1956. 2. Matlin, E.: M. Times *84*:68 (Jan.) 1956. 3. Hodge, J., Sokoloff, M., and Franco, F.: Am. Pract. & Digest Treat. *10*:473 (March) 1959. 4. Burros, H. M., and Borromeo, V. H. J.: J. Urol. *76*:456 (Oct.) 1956. 5. Lane, R. A.: New York J. Med. *55*:2343 (Aug. 15) 1955.

For complete information about Doriden (including dosage, cautions, and side effects), see current Physicians' Desk Reference or write CIBA, Summit, N. J. 2/2985MB

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active antihypertensive
broad benefit
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foremost flexibility
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– The clinical effectiveness and favorable sodium/potassium ratio of RENESE at 0.5 mg. and at 16 times that dose (8 mg.) may make thiazide therapy available to patients previously excluded either by intolerance at the lowest available doses of other agents or by lack of response at their highest effective doses. The availability of RENESE in 1 mg., 2 mg., and 4 mg. scored tablets provides a dosage form for *each* and *every* patient – mild, moderate or severe.

"For Product Information turn to page 36"

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VOL. 2, NO. 18

MEDICAL WORLD NEWS

THE NEWSMAGAZINE OF MEDICINE

SEPTEMBER 1, 1961

CONTENTS

On the cover: Transillumination aids diagnosis of an infant who developed acute hydrocephalus following an injury. Serial photographs reveal progressive replacement of brain tissue by fluid. Story on p. 26.

Departments

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LATEN

'PUFFMETER' AIDS NEW TYPE OF MASS SCREENING PROGRAM

Success of the first mass screening program for chronic, but asymptomatic, respiratory disease has been attributed to the "puffmeter," an instrument for making rapid simple pulmonary function tests.

Dr. Charles I. Leftwich and his associates at Santa Clara County Tuberculosis and Health Association, San Jose, Calif., point out that this instrument, combined with a minifilm chest x-ray and vitalometer to measure total and three-second timed vital capacities, efficiently uncovers the one feature common to most pulmonary diseases—ventilatory obstruction.

And, they say, it is fast: They surveyed 3,084 asymptomatic persons in a week, or 500 to 600 per six-hour working day.

Evidence of ventilatory obstruction was found in 110 of the group. The

confirmatory studies revealed that 73 of them had "definite or probable chronic pulmonary disease," Dr. Leftwich says. The information was sent to each person's physician for follow-up examination.

AORTIC VALVE YIELDS ITS OWN 'PROSTHESIS'

When use of a prosthetic heart valve is undesirable, advanced aortic stenosis can be corrected with a flap-valve made from the aortic wall itself, reports Dr. Charles P. Bailey of New York Medical College. (See *Outlook*, p. 13.)

The procedure is particularly use-

ful when all three cusps are so prolapsed "that they can no longer hold water—or blood," says Dr. Bailey. He begins by removing the non-coronary cusp and suturing a portion of the aorta to the margins of the remaining two cusps. The aorta is then incised so that a two-inch long portion of its wall can act as a flap-valve. This unicuspid valve is pushed aside during systole, and closed when the aortic blood tends to fall back during diastole. The missing portion of the aortic wall is rebuilt with a patch of Teflon mesh; the orifice left by the excised cusp serves as the lumen of the reconstructed artery.

The new concept, developed in experiments on dogs, has proved successful on one human being, though the patient died later of secondary infection. Dr. Bailey, a long-time pioneer in heart surgery, believes the new technique may be his most important innovation.

STUDY SHOWS ADOPTION NO CURE FOR INFERTILITY

The belief that a childless couple who adopts a child is more likely to conceive afterward—a perennial item of popular gynecological folklore—is almost certainly false, says Dr. A. Lawrence Banks of Seattle.

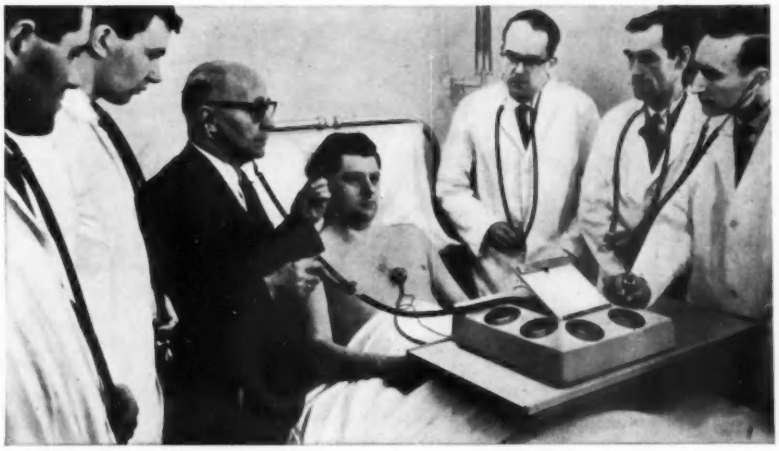
Dr. Banks and his colleagues, Drs. R. N. Rutherford and W. A. Coburn, have studied 31 infertile couples over periods ranging from one to nine years after adoption of children. Only one of the women in the group subsequently achieved a normal pregnancy, and hers followed myomectomy, lysis of pelvic adhesions and tubal lavage. Conception, therefore, "could hardly be attributed to any type of emotional or organic change produced by the adoption."

The study group included 11 couples in whom no physical or emotional reason could be found for prolonged infertility. None of these conceived following adoption.

Dr. Banks notes that his findings support earlier studies by public adoption agencies who found that later pregnancies achieved by adoptive parents were less than the normal ten per cent of spontaneous infertility cures.

The belief that adoption spurs fertility should be refuted "as a humanitarian service to our patients," says Dr. Banks.

SEVEN STETHOSCOPES IN SEARCH OF A MURMUR



Six medical students and their instructor can now tune in together to one beating heart, say the British manufacturers of a new teaching device.

The Amplivox Multi-Channel Stethoscope picks up the patient's heart sounds through a contact microphone and transmits them, without distortion, to seven diaphragms placed around the periphery of the apparatus. The students place their stethoscopes against the diaphragms rather than against the chest wall; the instructor, also "tuned in," hears what they hear and can question them or comment on the case accordingly.

Transistorized, the device weighs only eight pounds.

NEW CHROMOSOME DEFECT DESCRIBED AS 'PARTIAL TRISOMY'

A new type of chromosome aberration has been reported by cytogeneticist Klaus Patau of the University of Wisconsin School of Medicine. It is an "insertion chromosome" containing a fragment, identical to a piece of a normal chromosome pair, spliced into its center.

The result, reported by Dr. Patau to the American Society of Human Genetics, is a "partial trisomy." A mother and a daughter, among the 20 known women with oral-facial-digital malformations, were found to have this karyotype. Although they had a "normal" chromosome count of 46, one of the largest chromosomes (#1) contained additional material identical to the middle region of another chromosome (one of the 6-12 group). But none of these chromosomes had any material missing.

Another partial trisomic has been found by Dr. Margery W. Shaw, instructor in human genetics at the University of Michigan School of Medicine: a partially mongoloid woman with 46 and "one-half" chromosomes. The half is tacked on the end of a chromosome of the 13-15 group.

Dr. Patau and Dr. Shaw believe that in both cases the surplus genetic material was apparently inherited by the offspring from another type of chromosome anomaly in the parents.

FIBRINOLYTIC THERAPY FOR THROMBOSIS EXAMINED

The continuing controversy over fibrinolytic therapy for thrombosis has been stimulated by two reports.

On the basis of precise animal experiments, a Yale University surgeon finds that most anti-thrombotic agents will dissolve clots *in vivo*—but not consistently. And a pioneer in thrombolysis research warns that currently employed fibrinolytics can cause anaphylactic shock if repeated.

Introducing his study of six thrombolytic drugs, Yale's Michael Hume notes that clinical thrombosis responds to therapy in ways that are "extremely hard to evaluate." Seeking a controlled technique for studying thrombolysis *in vivo*, he has devised a method of lodging radioac-

CONTINUED ON PAGE 6

tively-labeled clots in dog's lungs, then measuring disintegration of the clot by charting changes in radioactivity over the dog's thorax and in blood and urine samples.

After testing two forms of streptokinase, three types of streptokinase-activated plasminogen and a sample of urokinase-activated plasminogen, he reports that all but one of the agents "dissolve some of the clots some of the time." However, none worked all the time, and few clots dissolved completely.

Dr. Hume finds little practical difference between streptokinase and urokinase preparations. In contrast, Dr. Julian L. Ambrus of Roswell Park Memorial Institute, Buffalo, warns that streptokinase, being made from streptococcus bacteria, produces antibodies after injection. If administered again, anaphylaxis could ensue.

Dr. Ambrus, who discovered the thrombolytic properties of urokinase, notes that both of the anti-thrombotic agents now on the market contain streptokinase. Administration of these drugs may elevate antibody levels for as long as two years. And strep infections during that period could raise antibody levels still further.

Clinical trials with urokinase, he declares, indicate that it is just as effective as streptokinase. And since it is a human enzyme, it produces no antigens. However, no urokinase-based agent is yet on the market.

MEDICAL 'GOOD SAMARITAN' SHOULD KNOW HIS LEGAL STATUS

If a physician stops at the scene of an accident, what sort of legal liability is he letting himself in for if he administers treatment?

What protection does he have if the patient later decides that the doctor's treatment contributed to or caused further injury?

Although a number of states are considering legislation that would relieve a physician of civil liability in such cases, only California and South Dakota have such "good Samaritan" bills on their statute books.

Connecticut, Hawaii, Indiana, Maine, Maryland, Massachusetts, Oregon, New York, Ohio, Pennsylvania, Texas and Wyoming either have bills pending or are interested in such legislation.

Philip R. Overton, general legal counsel for the Texas Medical Association, said the Texas bill provides that: "No person shall be held liable in civil damages who administers in good faith emergency care at the scene of an emergency for acts performed during the emergency unless such acts are willfully or wantonly negligent.

"Negligence," the lawyer emphasizes, "is always a cause of action for the injured party."

May a physician who is in a state in which he is not licensed treat an individual in an emergency?

"Yes," says Overton. While normally a physician must be licensed by the state in which he practices, an exception is made for emergency care.

As for performing an emergency operation, Mr. Overton said that authority to proceed with such surgery without consent involves three points:

- The injured person must be unconscious or otherwise unable to give a valid consent—such as a child or a person of unsound mind.
- The situation must be such that it is actually or apparently necessary to take some action before there is an opportunity to obtain consent.
- The physician must utilize every available technique or equipment to confirm a diagnosis. If he fails to do so, liability exists if an incorrect diagnosis leads to incorrect treatment.

MEDICAL FEES RISE IN TEN OUT OF ELEVEN OF LARGEST U. S. CITIES

Doctors in 11 major cities are charging their patients more than in 1958, says the U. S. Bureau of Labor Statistics. But the pattern of increase, as well as differences among major cities, shows little consistency.

Los Angeles still leads the nation in fees for office visits with an average fee of $6.25 in 1960 (up 17 per cent since 1958). The sharpest increase has come in New York, where physicians boosted their office charges 44 per cent and home-visits 90 per cent. Los Angeles, San Francisco and New York, tops in office charges and house visits, also lead in fees for appendectomies, tonsillectomies and obstetrical cases (see chart).

Medical supply and demand — as measured by the ratio of population to physicians—appears to have little effect on fees charged. While Los Angeles has both the highest ratio and the highest fees, San Francisco, second in fees, has one of the lowest ratios.

		OFFICE VISIT	HOUSE VISIT	OBSTETRICAL CASE	APPENDECTOMY	TONSILLECTOMY
ATLANTA	1958	$4.17	$7.75	$155.83	$150.00	$79.17
	1960	4.24	7.65	156.67	158.33	79.17
BOSTON	1958	$3.43	$5.14	$138.17	$170.83	$65.83
	1960	4.64	5.91	138.83	170.83	70.83
CHICAGO	1958	$4.33	$7.33	$135.00	$162.50	$83.33
	1960	4.88	7.88	158.33	162.50	83.33
CINCINNATI	1958	$3.33	$5.67	$104.67	$150.00	$67.50
	1960	4.00	6.06	111.08	154.17	73.00
LOS ANGELES	1958	$5.33	$8.67	$175.00	$233.33	$100.00
	1960	6.25	11.36	179.17	237.50	112.50
MINNEAPOLIS	1958	$3.17	$6.00	$114.17	$164.29	$52.00
	1960	4.00	7.44	116.67	179.17	70.83
NEW YORK	1958	$3.83	$4.83	$174.50	$178.50	$89.17
	1960	5.50	8.22	181.50	195.83	105.83
PHILADELPHIA	1958	$3.25	$4.17	$148.33	$154.17	$64.17
	1960	4.19	6.06	170.83	135.83	70.00
SAN FRANCISCO	1958	$5.00	$7.83	$163.57	$208.33	$95.83
	1960	5.94	9.19	185.00	246.67	100.00
ST. LOUIS	1958	$3.57	$5.43	$116.67	$175.00	$75.83
	1960	4.28	7.39	125.00	180.00	77.00
WASHINGTON	1958	$4.33	$5.50	$149.17	$142.86	$69.17
	1960	4.86	7.11	154.00	146.43	69.17

Source: Health Insurance Institute

TABLETS

INJECTION

FOR YOUR PATIENT WITH DEPRESSION

ELAVIL®

AMITRIPTYLINE HYDROCHLORIDE

the antidepressant with a significant difference: • given orally or parenterally, ELAVIL provides PROMPT relief of associated anxiety, tension, and insomnia • followed by control* of underlying depression

*Some depressed patients respond within 5 to 10 days, while others may require up to two weeks or longer to obtain benefit.

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- a single agent (not a combination of compounds)
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- may be used in ambulatory or hospitalized patients
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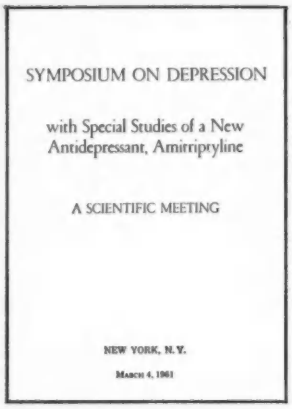


EXCERPTS FROM A SYMPOSIUM ON DEPRESSION

ELAVIL®

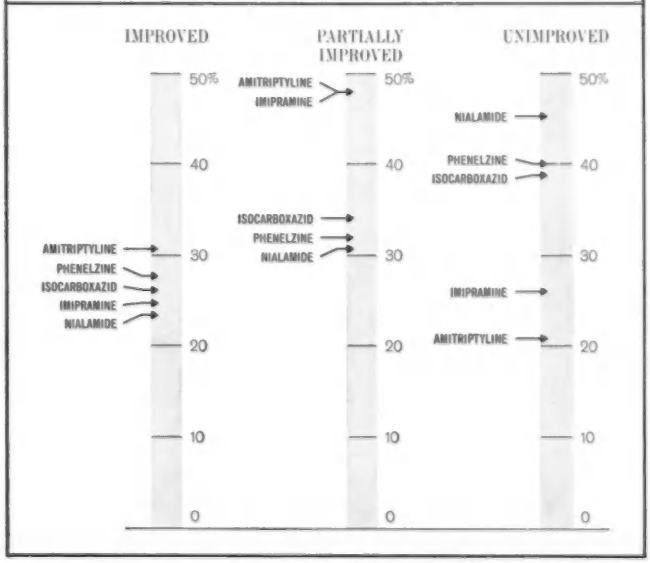
AMITRIPTYLINE HYDROCHLORIDE

INVESTIGATOR	FINDINGS
DUNLOP, EDWIN: The treatment of depression in private practice.	"Amitriptyline [ELAVIL] has a specific advantage over any antidepressant currently available and I see increasing evidence of its usefulness in reducing tension, agitation and anxiety, as well as in relieving the depressive quality of the illness. Amitriptyline appears . . . to combine better than any other antidepressant drug the successful treatment of anxiety at one end of the scale and depression at the other. Experience in the past has shown us that, when using electroshock or analeptics, although depression can be relieved, the accompanying anxiety eventually proves more troublesome than the depressive phase of the illness. Amitriptyline successfully bridges these divergent symptoms which are displayed in varying proportions in all depressive syndromes. ". . . Approximately one hundred and twenty patients have been studied with amitriptyline during the last fifteen months. It is an effective antidepressant when employed in both hospital and ambulatory patients. Its dependability and freedom from toxicity and severe side effects merit further evaluation on a broader spectrum of depressive disorders."
BENNETT, DOUGLAS: Treatment of depressive states with amitriptyline.	"In those cases showing a good response, early and dramatic improvement in sleeplessness resulted and many patients noted a feeling of relaxation. The ability of some patients to reduce their night sedatives after only a month's treatment was unique in my experience of the treatment of depression."
SAUNDERS, JOHN C.: Antidepressives: the pith of affective therapy.	"Its primary action in hospitalized psychotics is antidepressive; this along with its very low rate of side actions make it a drug of potentially frequent application in a broad spectrum of neuropsychiatric diseases. . . . Since a large part of any hospital population will reach a plateau if given only a tranquilizer or an energizer, we suggest that amitriptyline alone be given prior to combination therapy, as this drug is easier and safer to administer and produces a significant improvement in a high percentage of cases (60-75)."
OSTFELD, ADRIAN M.: Effects of an antidepressant drug on tests of mood and perception.	"Finally, it appears that amitriptyline in the doses employed here is relatively effective in depressed states of neurotic proportions. Its freedom from severe side effects in doses that are therapeutically effective seems established in this patient population."

(This symposium was published in Diseases of the Nervous System, Volume 22, Section Two—Supplement, May 1961)

INVESTIGATOR	FINDINGS
AYD, FRANK J., JR.: A critique of antidepressants.	"Amitriptyline and imipramine induce similar side effects but, generally speaking, those of amitriptyline cause less subjective discomfort in patients than those of imipramine. "... Many of the factors that favor a satisfactory response to these drugs are also those clinically associated with the expectation of a good reaction to ECT. The danger lies in their general slowness in taking effect which makes their use hazardous for severely depressed suicidal patients who, preferably, should be treated with electroshock therapy. Otherwise, these compounds can be a satisfactory substitute for shock therapy for most depressed patients. Thus, these drugs have lessened the need for ECT. On those occasions when ECT is necessary, if the shock therapy is combined with an antidepressant, ECT can be dispensed with after a few treatments."

COMPARISON OF THERAPEUTIC RESULTS WITH VARIOUS ANTIDEPRESSANTS



please turn page

EXCERPTS FROM A SYMPOSIUM ON DEPRESSION (continued)

ELAVIL®

AMITRIPTYLINE HYDROCHLORIDE

INVESTIGATOR	FINDINGS
DORFMAN, WILFRED: Masked depression.	"In evaluating the effectiveness of amitriptyline in all these different settings, it was considered to be effective in 17 of the 25 patients (68%)."
FELDMAN, PAUL E.: Psychotherapy and chemotherapy (amitriptyline) of anergic states.	"Compared to other energizer compounds, particularly the hydrazines, amitriptyline appears to be relatively nontoxic. The laboratory reports for the most part remained within normal limits. Occasionally, abnormal readings were reported, but these appeared only sporadically and were not related to any clinical findings."

INDICATIONS: manic-depressive reaction—depressed phase; involutional melancholia; reactive depression; schizoaffective depression; neurotic-depressive reaction; and these target symptoms: anxiety; depressed mood; insomnia; psychomotor retardation; functional somatic complaints; loss of interest; feelings of guilt; anorexia. May be used whether the emotional difficulty is a manifestation of neurosis or psychosis,[1] and in ambulatory or hospitalized patients.[1,2,3]

USUAL ADULT DOSAGE: Tablets – initial dosage 25 to 50 mg. three times a day, depending on body weight, severity, and clinical disturbances. Dosage may be adjusted up or down depending upon the response of the patient. Some patients improve rapidly, although many depressed patients require four to six weeks of therapy before obtaining antidepressant response. For the ambulatory patient the dosage range for Tablets ELAVIL is 40 to 150 mg. daily. In the hospitalized patient, a daily dosage up to 300 mg. may be required. Injection ELAVIL may be given IM to rapidly calm depressed patients with symptoms of anxiety and tension while instituting therapy of the underlying depression. Initial therapy is 2 to 3 cc. (20 to 30 mg.) IM, q.i.d.

The natural course of depression is often many months in duration. Accordingly, it is appropriate to continue maintenance therapy for at least three months after the patient has achieved satisfactory improvement in order to lessen the possibility of relapse, which may occur if the patient's depressive cycle is not complete. In the event of relapse, therapy with ELAVIL may be reinstituted.

ELAVIL is not a monoamine oxidase (MAO) inhibitor. It does, however, augment or may even potentiate the action of MAO inhibitors. Thus, in patients who have been receiving MAO inhibitors, ELAVIL should be instituted cautiously after the effects of the MAO inhibitors have been dissipated. No evidence of drug-induced jaundice, agranulocytosis, or extrapyramidal symptoms has been noted. Side effects with ELAVIL are seldom a problem and are not serious. They are dosage-related and have been readily reversible. Side effects (drowsiness, dizziness, nausea, excitement, hypotension, fine tremor, jitteriness, headache, heartburn, anorexia, increased perspiration, and skin rash), when they occur, are usually mild. However, as with all new therapeutic agents, careful observation of patients is recommended. As with other drugs possessing significant anticholinergic activity, ELAVIL is contraindicated in patients with glaucoma, prostatic hypertrophy and urinary retention.

SUPPLY: Tablets, 10 mg. and 25 mg., in bottles of 100 and 1000. **Injection** (intramuscular), in 10-cc. vials, each cc. containing 10 mg. amitriptyline hydrochloride, 44 mg. dextrose, 1.5 mg. methylparaben, 0.2 mg. propylparaben, and water for injection q.s.

REFERENCES: 1. Ayd, F. J., Jr.: Psychosomatics 1:320, Nov.-Dec. 1960. 2. Dorfman, W.: Psychosomatics 1:153, May-June 1960. 3. Barsa, J. A., and Saunders, J. C.: Am. J. Psychiat. 117:739, Feb. 1961.

Before prescribing or administering ELAVIL, the physician should consult the detailed information on use accompanying the package or available on request.

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A LETTER FROM THE PUBLISHER

The biggest problem facing American medicine is not nationalization or the final defeat of this or that disease; it is perpetuation of the profession as a virile . . . force in the American community.

This statement by Dr. James D. Murphy, president-elect of the American Academy of General Practice, was written as part of a concerted effort to enlist physician support for the AAGP's drive to interest more young people in becoming doctors.

This fall the AAGP will launch Project MORE, an attempt to show both high school students and their parents the rewards of a medical career, while at the same time demonstrating how deeply we all are affected by the dwindling number of physicians.

DR. M. C. ROLLER welcomed by Chetek, Wis.

MEDICAL WORLD NEWS has frequently discussed the physician shortage. Last issue I devoted this space to one aspect of this problem—the need to attract young doctors to smaller communities.

This is, of course, no easy job. In a recent speech, Dr. Edward C. Hughes, chairman of the committee on Rural Medical Services of the New York Medical Society, pinpointed a main reason for this shortage in our outlying areas. Despite many good local hospitals, smaller communities, he said, are having a difficult time competing with large urban centers, which offer medical graduates a wide variety of modern scientific facilities.

One of the programs specifically designed to help small towns overcome this disadvantage is the Community Medical Assistance Program in Chicago, sponsored by the Sears-Roebuck Foundation and the AMA . The Foundation has spent about $7,000 in each of some 57 communities to show townspeople, how, as Foundation president James Griffin puts it, "to create facilities that some young physician should find irresistible." In the 3½ years since its inception, the Community Medical Assistance Program has helped more than 158,000 people obtain their own physicians.

We'd like MEDICAL WORLD NEWS to do its part in helping solve this problem. As a newsmagazine distributed throughout the country, we want to make a special effort to let physicians know about openings that come to our attention. Last issue, for instance, we published an item about several medical personnel positions available in Veterans Administration hospitals (*Doctor's Business,* p. 42). And just recently, Dr. Fishbein received a letter from Dr. Paul A. Lembcke, professor of Public Health and Preventive Medicine at UCLA Medical Center, seeking help in finding qualified lecturers in hospital and medical care administration.

If you or your community are looking for medical personnel, we hope you, too, will let us know.

M M Geffen

Publisher

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OUTLOOK

- **Draft-age doctors get Selective Service warning**
- **Tests are set for plastic surgical instruments**

It's possible that draft-age doctors who haven't applied for service commissions may wind up performing surgery on potatoes while doing KP as Army privates. Selective Service officials point out that special treatment for men with medical degrees is a thing of the past, and that doctors are now just as recruitable as anyone else. If a young doctor waits too long, he may still apply for a commission after being drafted, of course. Meantime, there is a good chance that he will have to serve as an enlisted man and undergo recruit training while he waits for his commission.

One reason Communist East Germany can be expected to make travel to the West still more difficult is that many of those fleeing to the West are professional people. Because of the flight of doctors, for example, there is now only one physician for every 4,400 patients in East Germany—one-fourth the number in West Germany.

A U.S. task force is being organized to map an attack on syphilis. The number of cases has tripled since 1957. Surgeon General Luther L. Terry says the five-member group will be ready to go to work by the middle of this month. Its report will form the basis of recommendations to Congress next year.

Is it possible to rest the heart during the crucial few days following a cardiac attack? Under Dr. Charles P. Bailey, chairman of the department of surgery at New York Medical College, a team of specialists will spend the next two years trying to find the answer. With experimental animals, they will test four heart-resting techniques: lowered body temperatures, heart pumps, reduced temperatures and heart pumps in combination and heart-lung machines. If the animals appear to benefit, it may be possible to try the same techniques on human patients.

Following the example of the AMA, the Pharmaceutical Manufacturers' Association will organize a speakers' bureau of its own. Speakers from 140 member firms will discuss drug prices, medical research, Federal controls, hospital costs and new discoveries in medicine. Purpose: to undo some of the negative publicity from the Kefauver hearings.

Ex-president Eisenhower will be the keynote speaker at a big fund-raising dinner in New York, October 23. The Eisenhower talk—on medical education—will highlight the 50th anniversary of the original affiliation between New York's Presbyterian Hospital and Columbia University.

The Army is perfecting surgical and dental instruments made from plastics. The Medical Equipment Development Laboratory says the devices, made of polycarbonate resins, withstand high autoclaving temperatures, have high tensile strength and are shock resistant. The instruments can be turned out on a mass basis, thus lowering costs and eliminating the use of strategic materials.

British specialists in rheumatology are deserting Great Britain for greener pastures. The London **Times** reports that "more than half the young men trained in rheumatology have been discouraged by the lack of opportunity in Britain and have gone overseas, where senior posts are available for men with special experience." Quoting a report on the problem, just issued by the Royal College of Physicians, the paper adds that "it is doubtful whether our young specialists are being given sufficient credit when they apply for consultant appointments."

Krebiozen booster Dr. Andrew C. Ivy says he has completed an analysis of 4,200 cancer cases treated with the controversial drug. His data will go now to the National Cancer Institute for the first controlled test ever run on Krebiozen.

MEETINGS

Sept.	**9-14**	Int'l Conference of Dermatology, Wash., D. C.
Sept.	**10**	Amer. Acad. of General Practice, Red River Valley, Oklahoma
Sept.	**10-14**	Int'l Tuberculosis Conference, Toronto
Sept.	**10-15**	Int'l Congress of Neurology, Rome
Sept.	**13-15**	Utah State Medical Assoc., Salt Lake City
Sept.	**14-16**	New England Society of Anesthesiologists, Portsmouth, N. H.
Sept.	**14-16**	Int'l Symposium on Chemotherapy, Naples
Sept.	**14-16**	Montana Medical Association, Great Falls
Sept.	**14-16**	American Association for Automotive Medicine, Minneapolis
Sept.	**15-20**	World Medical Association, Rio de Janeiro
Sept.	**17-20**	Wash. State Medical Association, Seattle
Sept.	**17-21**	American Fracture Association, Wash., D. C.

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IN GENITOURINARY INFECTIONS

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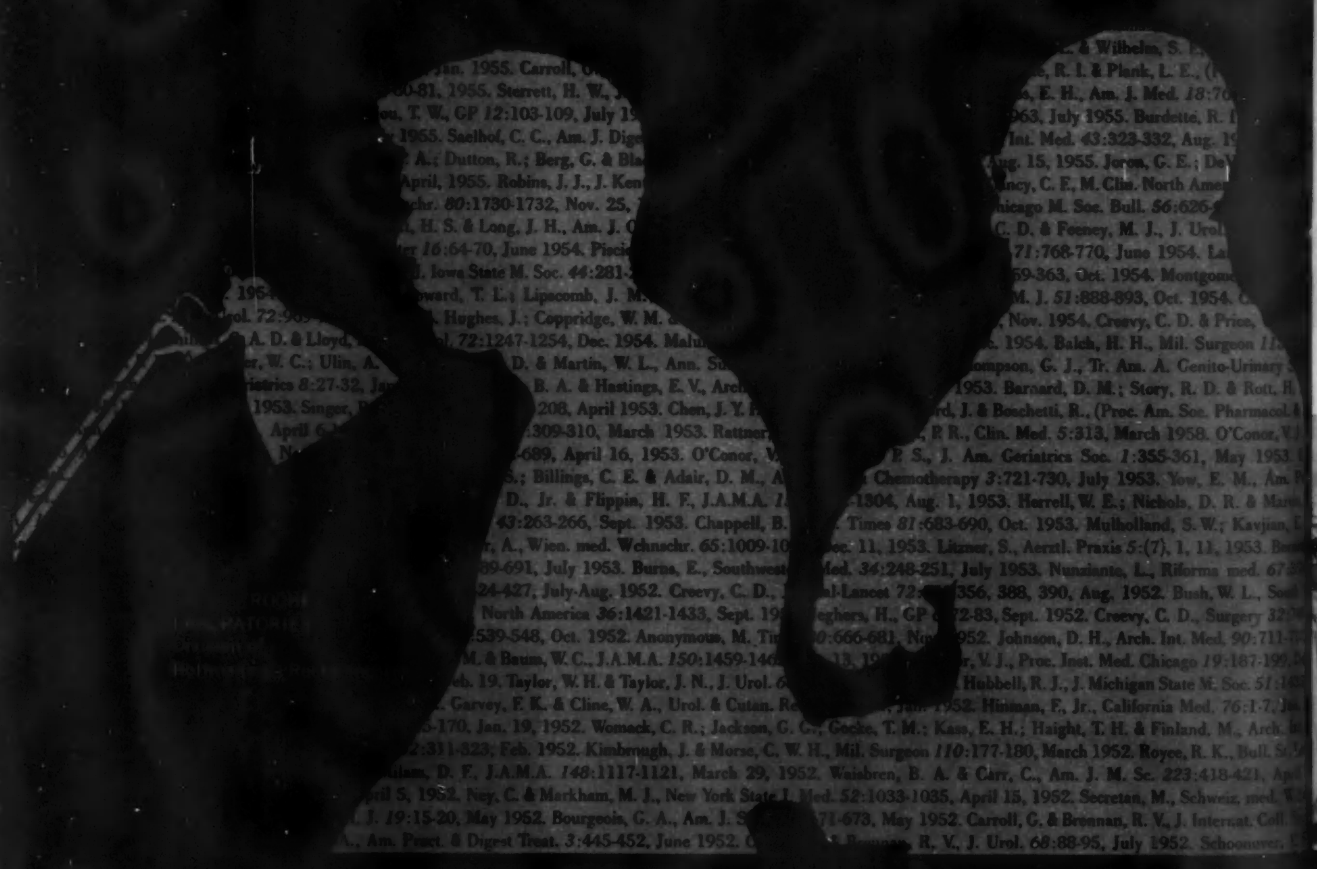

MEDICAL WORLD NEWS
September 1, 1961 Vol. 2, No. 18

FIRST LIVE POLIO VACCINE GETS GO-AHEAD

Sabin Type I strain will be stockpiled for epidemic use. Approval of Type II is expected soon, but Type III presents problems

After months of cautious evaluation—and considerable controversy—the U. S. Public Health Service has cleared the first commercial lots of oral polio vaccine. Nearly one million doses of Type I vaccine have been approved for general use.

Surgeon General Luther L. Terry announced, however, that the initial output is being bought by the Health Service. He said that it will be "held in reserve by the Service's Communicable Disease Center for use and study in the event of an epidemic threat of Type I virus anywhere in the U.S."

The Government, which has trailed Russia, Britain and other countries in endorsing the live virus vaccine, will also announce release of the first batches of Type II vaccine "in the near future." But, Dr. Terry said, approval of the troublesome Type III vaccine "will be delayed for several months at least."

Informed sources reveal that this strain, the most unstable of the three developed by Cincinnati's Dr. Albert Sabin, hit a snag when the first production lots were subjected to the tough tests required by the biologic standards division of the National Institutes of Health.

Dr. Sabin maintains that the strain's safety in man is not at issue. As evidence, he cites the more than 275,000 Type III doses produced in his own lab and recently fed safely to children in the Atlanta area to curb a threatened outbreak. But the problem of fitting the first commercial batches to the rugged NIH standards *has* prevented immediate approval.

The Type I vaccine cleared by PHS is manufactured in the British laboratories of Chas. Pfizer & Co. Pfizer got a head start in submitting lots for U. S. approval because its overseas subsidiary had pioneered in large-scale production of the Sabin vaccine, which NIH finally adopted as the American standard. Wyeth Laboratories and Lederle Laboratories are also working on the vaccine, but their preparations are not included in the initial release.

Dr. Terry announced that the first production vaccine, purchased with a special $1 million appropriation (nine cents a dose), will be made available to state and territorial health departments meeting four basic requirements: 1) at least three confirmed Type I polio cases reported in the community within one month; 2) adequate community organization and medical leadership "to insure rapid and complete coverage of the population under age 50"; 3) agreement to make vaccine available "without charge"; and 4) channelling of local requests through state health departments.

PHS decided to release the Type I vaccine ahead of Types II and III because it was "ready to go first," and because it could be used immediately in case of an epidemic.

"We'd be derelict in our duty if we didn't make the Type I available just as soon as it measured up to standards," a PHS official told MEDICAL

CONTINUED ON PAGE 16

VACCINE production is already well under way. Viruses are grown in nutrient flasks and tested in lab animals.

WORLD NEWS. "Historically, Type I has caused more paralysis than any of the other strains, so this vaccine could be very helpful under certain circumstances."

Dr. Terry reported that "the total number of cases this year is the lowest since 1912 when polio cases were first collected." The 234 paralytic cases reported during the first 31 weeks this year were sharply down from the 680 reported during the same period last year, and the five-year median of 1,596. The total was 62 per cent below the previous low of 1958.

By the time the next polio season rolls around, the experts are hopeful that they will have settled the problems of Type III sufficiently to permit clearance of all three strains for general use by physicians, as well as for mass immunization programs in case of epidemics. The final solution may be the adoption of a different reference strain.

From the very beginning, Sabin Type III has presented difficulties. In recommending adoption of the Sabin strains a year ago, the PHS Committee on Live Poliovirus Vaccine noted that Type III has "less than optimum immunogenic capacity" and shows "a tendency to change its neurovirulence." The Committee called for a "continued search for a superior Type III strain."

Under PHS regulations, five consecutive lots of production vaccine must fail to produce any significant CNS damage in monkeys, when injected intraspinally and intrathalamically. The attenuated virus must also show a 100,000-fold drop in activity when its incubation temperature is raised from 36° C to 40° C.

Some scientists argue that these tests are too tough for Type III. They say that this strain is basically different from the others, and should not be required to meet standards that are based on the characteristics of the more stable Type I.

Public Health officials and their advisory committee have, however, adopted a go-slow policy. Only one firm has submitted production data on Type III; the Service says it wants to see more information on the experience of all the manufacturers before considering changing standards. Mindful of the Cutter incident in 1955, it wants to err on the side of caution.

Dr. Sabin, members of the PHS vaccine committee and industry representatives met secretly at NIH recently to thrash out the whole oral vaccine problem. One of the chief issues was interpretation of the neurovirulence and temperature tests in the case of Type III.

Officials said it may turn out that the manufacturers can make Type III measure up to the standards, or, more unlikely, that some changes in the regulations may be warranted. Another possibility is the adoption of a different reference strain.

Reportedly, Dr. Herald R. Cox of Lederle, one of the pioneers in the development of attenuated polio virus vaccines, is convinced that a Type III strain he is working with is far more stable than the Sabin III. If tests show that it has comparable or superior antigenic properties, Lederle believes it has a good chance of meeting the NIH standards, without the same difficulties encountered by Dr. Sabin's Type III.

Although Dr. Sabin himself declined to disclose what transpired at the NIH meeting, he insisted afterward that "there is no problem at all with Type III." He said the difficulty lay in the interpretation of slight variations in a test result. In his view, the issue was related entirely to the usual complications that develop in moving a vaccine from the laboratory to the production line. He remained optimistic that Type III lots would be cleared in due time.

The real evidence of vaccine safety, Dr. Sabin insists, is the fact that it has been given to millions of people around the world without incident. Other scientists involved in the Type III problem also said they were confident that it was safe for man, although its instability posed some technical problems. The British Medical Council recently put its official stamp on the Sabin vaccine, including the controversial Type III. And a series of scientific reports just published in the *British Medical Journal* did not emphasize any problems with the third strain.

Another roadblock hampering, if not halting, American manufacturers has been monkey viruses — the so-called SV 40 and Foamy viruses — which find their way into kidney tissue cultures. This, however, is being overcome, although with some difficulty. ■

RUSSIANS PREDICT POLIO ERADICATION

Success of the live polio virus immunization program in the Soviet Union has raised hopes that the disease may be completely eradicated within five years, Dr. Victor Zhdanov, director of the Institute of Virology and chief scientific secretary of the USSR Academy of Medical Sciences, told MEDICAL WORLD NEWS.

For the past year, production of attenuated vaccine and its distribution throughout Russia has been under the direct authority of the Academy's Institute of Poliomyelitis, headed by Dr. Michail Chumakov, prime mover of Russia's mass immunity project. As a result, the Institute (a former rest home 20 miles outside Moscow) has become the world's largest producer of polio vaccine. Together with the Marat candy factory in Moscow, it produces literally tons of varicolored candies containing vaccine against a single strain, or all three strains.

Killed virus vaccine has been almost entirely discarded in Russia; it's still used only in small areas, serving largely as controls, and Soviet scientists call the results disappointing. In the Krasnodar region, for instance, a killed virus vaccine was used; paralytic polio incidence in 1960 was 234 per cent of that in 1959, while incidence in the USSR as a whole dropped to 57.3 per cent of the 1959 level.

Soviet scientists, therefore, now unanimously agree on the advantage of the live virus vaccine. So far, they note, no ill effects have been observed from use of the weakened live virus. Interference with immunization from other enteroviruses of ECHO or Coxsackie groups has occurred—especially during summer months when such viruses are more abundant. But the Institute report says the problem can probably be overcome by massive vaccination involving at least half of the susceptible population, and by repeated vaccinations for at least three years. Such revaccination has already been completed in Latvia.

MAJOR ROLE SEEN FOR BASOPHIL

New test focuses attention on the key part that this blood cell plays in the transport of lipids, and in allergic reactions

The basophil, long upstaged by more glamorous varieties of leukocyte, has now been thrust into the spotlight. University of Pennsylvania investigators have picked it for a major role in lipid transport and allergic reactions—and probably also in blood coagulation, clot lysis and atherosclerosis.

For years a mystery to hematologists, the basophil has remained a bit player in the cast of blood cells despite its great metabolic potential. It makes up no more than two per cent of the leukocyte population, but it is loaded with chemicals involved in a variety of critical physiological processes—heparin, histamine and perhaps plasmin as well.

Its overnight rise to cytological prominence stems from the discovery by two dermatologists of the first technique for finding out, *in vivo* and *in vitro,* just what the basophil does with all its metabolic talent. Though their basophil story is still developing, Drs. Walter B. Shelley and Lennart Juhlin have already sketched out two important discoveries.

They have found that following a fatty meal the basophil dumps heparin granules into the bloodstream, thus triggering the lipid "clearing" reaction. And they have uncovered individual differences in the rate of dumping which, they believe, suggest that the basophil's role in fat transport "may be a critical determinant in the pathogenesis of atherosclerosis."

Moreover, Drs. Shelley and Juhlin now have evidence that the basophil may be the cell responsible for the histamine shock of anaphylaxis. In patients hypersensitive to cold — a condition closely analogous to anaphylaxis — basophils rapidly release histamine granules in the presence of a specific "antigen." Thus, the new test may prove to be a diagnostic means of picking up a patient's anaphylaxis potential.

Essentially, the test is a means of directly observing the cell's activities, revealed by a degranulation response to specific stimuli. Venous blood is shot rapidly into a cold fixative to destroy all erythrocytes; basophils are concentrated on a membrane filter, then stained and fixed on slides. The effect of a given stimulus shows up in "before" and "after" comparison of the basophil count patterns.

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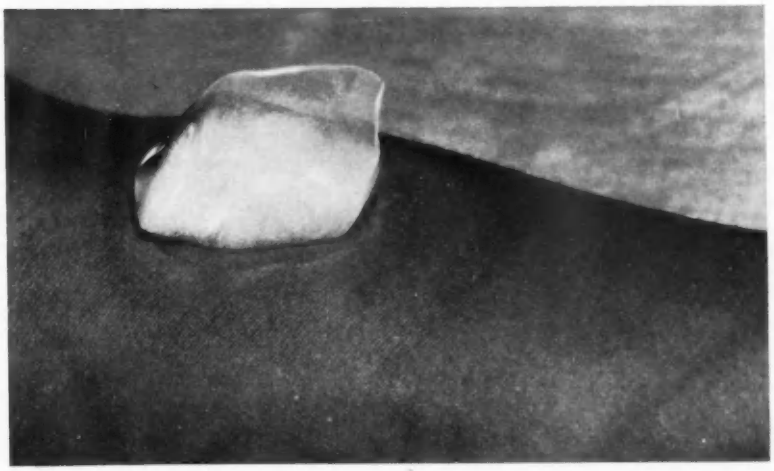
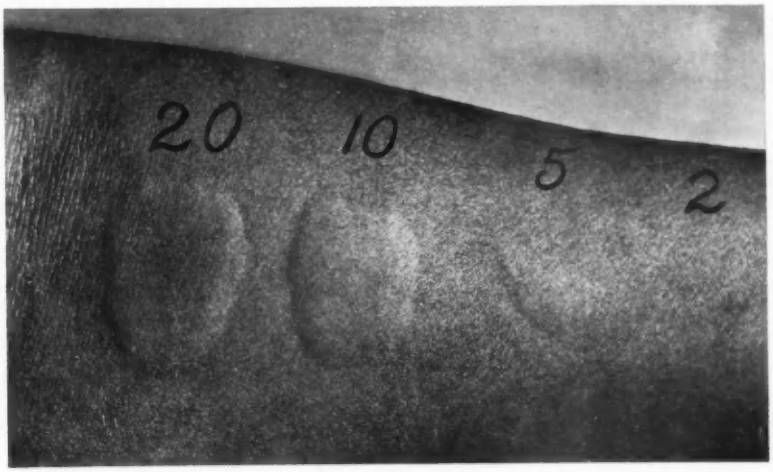
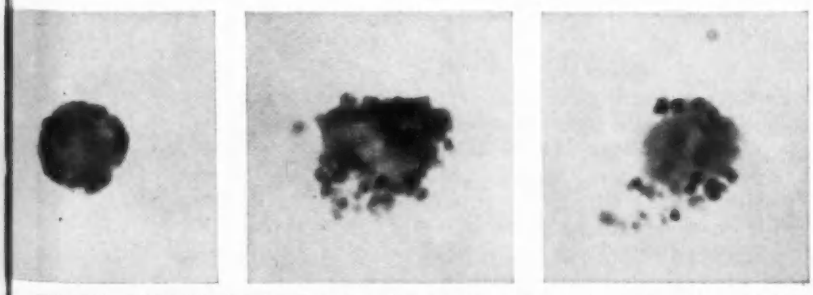


ICE CUBE is placed on forearm of subject to test his reaction to cold. Resulting urticaria varies in severity with the number of seconds patient's arm is exposed.





NORMAL BASOPHIL (l.) degranulates after cold exposure (c.) or after fatty meal (r.).

DR. LENNART JUHLIN studies basophils.

BASOPHIL ROLE CONTINUED

The new technique is the outgrowth of a search, supported by the Armed Forces Epidemiological Board, for a laboratory test of penicillin sensitivity. Since the urticaria sometimes induced by penicillin is caused by histamine released in the skin, dermatologist Shelley turned to the basophil, the blood's histamine carrier, to see if it was responsible for systemic penicillin reactions.

The Pennsylvania team has now shown that the basophil is indeed one of the cell types responsible for penicillin sensitivity. Basophils of patients with this allergy break up in the presence of the drug, shooting histamine granules into the bloodstream.

Histamine Granules Unloaded

Moreover, they find that the same response occurs in cases of cold sensitivity marked by histamine release. A study of two such patients, report Drs. Shelley and Juhlin in a recent issue of the *Journal of the American Medical Association,* has shown "for the first time" that their basophils undergo dramatic changes in the presence of cold. In both cases, an ice cube pressed against the arm produced urticaria in ten to 20 seconds; blood samples drawn from these patients and exposed to an ice bath seven to ten minutes later clearly showed the basophils unloading histamine granules.

In acquired essential cold urticaria, the local and systemic signs "are due to histamine release from the mast cell of the skin and the basophilic granulocyte of the blood," they conclude. The basophil sensitivity test, they suggest, "may be useful in detecting otherwise occult cold hypersensitivity."

More recently, Drs. Shelley and Juhlin have focused their attention—and their test—on the heparin-loaded basophil's role in fat transport. The fact that heparin triggers the release of blood lipase has been known for some time. But whether lipemia of itself mobilizes endogenous heparin has not yet been established. The two investigators theorized that "if the clearing reaction is a basic or intrinsic physiologic regulatory mechanism, lipemia might induce morphologic changes in the basophil," thereby setting off heparin mobilization.

As a test, they fed volunteers massive amounts of butter (4 gm per kg body weight, eaten only with bread). "The reason for this enormous dose," explains Dr. Shelley, "was to get an absolutely clear answer. The release of small amounts of heparin by the basophil would not be detectable with our rather gross cytological technique. It was necessary to swamp the organism with fat to get conclusive histological proof."

Individual Response Differences

The greasy meal caused degranulation of basophils after two to three hours in about 75 per cent of the volunteers, the Philadelphia investigators report in the *American Journal of the Medical Sciences.* Vegetable fats produced the same response. But equal quantities of carbohydrates or protein had no effect.

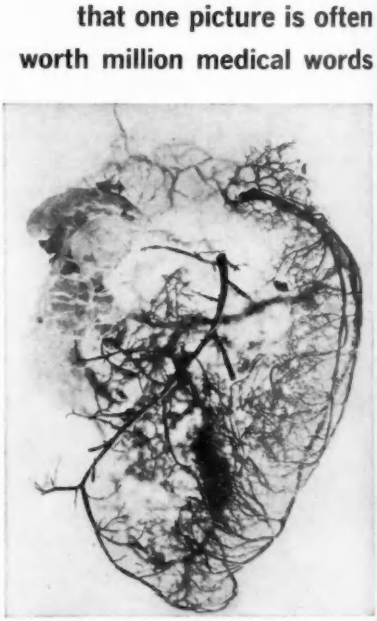
Furthermore, the volunteers showed individual differences in response. The lowest degranulation, curiously, was found among individuals whose rate of fat absorption was either lower or higher than average. This finding in the latter group, says Dr. Shelley, must be thoroughly investigated. "It suggests," he points out, "that one of the metabolic errors that leads to atherosclerosis may be the defective-functioning basophil."

Dr. Shelley cautions that their work with the basophil is preliminary, and thus far their technique shows only the gross morphological changes that occur in the presence of various stimuli. Nevertheless, they state, "in fat transport, there is now little doubt that the basophil is somehow intimately involved in the basic physiologic regulatory mechanism." ■

CLEANING UP: "Rehabili… New York, wins first prize… tated Art… in the G…

CAMERAS CLI…

Biological photographers' annual exhibit proves again that one picture is often worth million medical words



REPLICA: "Cast of Cardiac Blood Vessels" wins Carroll Weiss another prize.

The… th… amon… paren… annua… togra… M… plus … phers…

LABY… Henry…

tated Arthritic," by Carroll H. Weiss, in the General Illustrative category.

MONTAGE: Patient photographed with x-ray of periostial fibrosarcoma, by Arthur Smialkowski, St. Michael's Hospital, Toronto, provides clinical comparison.

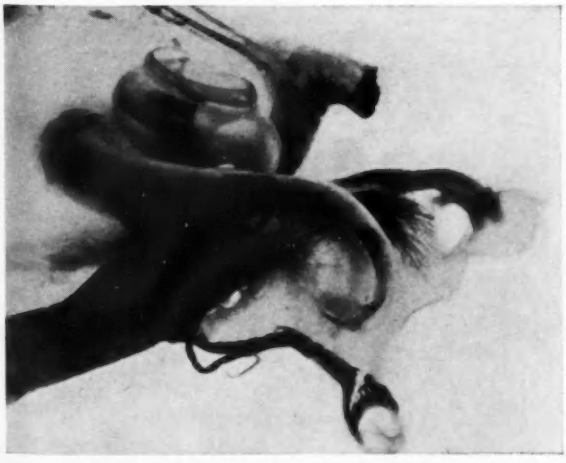
CLICK AS CLINICAL TOOLS

The photographs reproduced on these pages are prizewinners from among 200 prints and 65 color transparencies exhibited in Chicago at the annual meeting of the Biological Photographic Association.

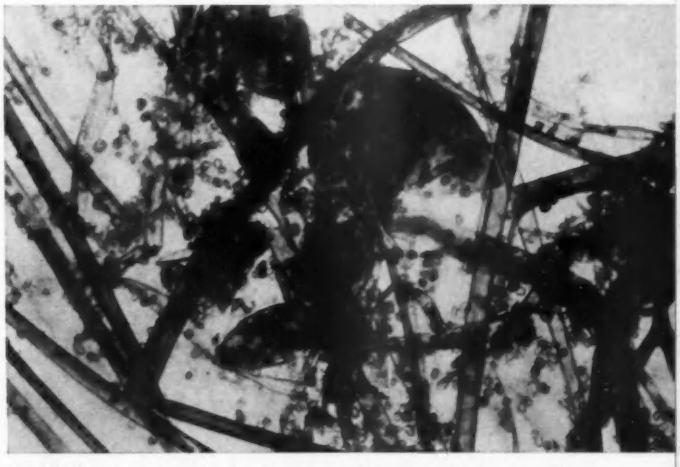
Most of the Association's 1,000-plus members are hospital photographers, though nature photographers and zoologists also belong and exhibit. Advances in biological photography shown included fiber optics and traveling microscopes, as well as fluorescence and time-lapse micrography.

For the highlight of the annual meeting — its salon — photographs were submitted from all over the world. The best among those selected for showing will tour the country, exhibiting at scientific meetings.

Participants at the Chicago get-together noted that the thriving specialty of biological photography has recently received an additional impetus from the proliferation of malpractice suits. Cautious physicians have found that photos make compelling evidence. ■



LABYRINTH: "Membranous Inner Ear," by Arthur J. Bowden, Henry Ford Hospital, Detroit, wins ribbon in Specimen class.



FUNGUS: Micrograph of pathogenic Rhizopus nigricans gets award for Charles A. Harris, St. Luke's Hospital, Milwaukee.

MOST PATIENTS LIKE DOCTORS

USPHS-sponsored survey shows that most Americans are well-satisfied with their physicians. But they appear to be less enthusiastic about the medical profession as a whole

The great majority of Americans are "entirely satisfied" with the treatment they receive from private physicians. They have high confidence in the ability of doctors to improve their health.

Ninety per cent are also convinced their doctors know "a lot more" than the physicians of 30 years ago. And, despite the reported trend toward impersonal medicine, almost half think they are getting more personal attention than did their parents and grandparents.

These observations are supplied by the U.S. Public Health Service, which sponsored a large-scale survey of patient attitudes. The study was designed to test potential public co-operation in free health examinations which the Service is planning to conduct as a supplement to its National Health Survey.

The results provided private physicians with some food for comfort—as well as a few disquieting facts. For they indicate that patients are, on the whole, favorably disposed toward their doctors, but they have some major and many minor complaints.

The National Opinion Research Center (NORC) of the University of Chicago conducted the study for PHS, carrying out detailed interviews with 762 persons between 18 and 65 who had previously participated in the National Health Survey's household interviews. More than 50 questions, many with multiple subsections, were asked in order to pinpoint attitudes toward health examinations in particular and medicine in general.

Although organized medicine is currently concerned about its so-called "image," the survey showed that 81 per cent of the 762 persons questioned were "entirely satisfied" with the treatment they had received from doctors in the past five years. Another 18 per cent said they were not satisfied with "some things" and one per cent expressed no opinion.

Usually the Other Fellow

When asked whether they knew anyone who had had a bad experience with a doctor, 78 per cent replied no. Only eight per cent reported having had a bad experience themselves.

A surprising 34 per cent of the study group said doctors nowadays have "much more" interest in their patients than they did 30 years ago. Another 14 per cent said they have a "little more." On the other hand, 14 per cent voiced the opinion that doctors are showing "much less" interest.

In listing their criticisms of doctors in general, 55 per cent of those polled cited "not enough personal interest." But in evaluating their own physicians, only 21 per cent had the same complaint, suggesting that the profession's general image is not as favorable as the individual doctor's standing with his own patients.

Interestingly, the chief complaint, which the group leveled both against their private physicians and the profession as a whole, was that "doctors don't set appointments right — you have to wait too long to see them." Fifty-five per cent of the 762 survey patients agreed on this failing.

Additional Criticisms

Other complaints against doctors in general were (in order of magnitude): Not enough free time for needy, give better care to regular patients, charge too much, fail to tell patient things he ought to know, don't give patient chance to tell trouble, more interested in making a lot of money than in finding out what is really wrong, don't like to consult other doctors, suggest unnecessary visits, work too fast—thereby making mistakes and giving unnecessary medicine.

Again these complaints didn't seem to be so pronounced when the survey patients were asked to consider their personal physicians. Although between 30 and 55 per cent indicted the profession generally on these counts, a very much smaller percentage felt that the charges applied to their own doctors.

Thus, while 46 per cent thought doctors in general charge too much, only 17 per cent made the same charge against their own physicians. Some 42

CONTINUED ON PAGE 23

HOW PATIENTS FEEL TOWARDS THEIR PHYSICIANS

NUMBER OF RESPONDENTS: 762

Satisfied with treatment?	
Entirely satisfied	81%
Some things not	18
Don't know	1

What are your criticisms of doctors in general?*	
Don't set appointments right	55%
Not enough personal interest	55
Not enough free time for needy	55
Give better care to regular patients	47
Too old-fashioned	15

*Mentioned voluntarily

Believe doctors know more today than 30 years ago?	
A lot more	90%
A little more	8
Less	1
The same	1

How do you rate care by salaried vs private physicians?	
Better	4%
Worse	25
Same	61
Don't know	10

More or less interest in patients today?	
More	48%
Less	34
Some	15
Don't know	3

Are today's medicines better than in the past?	
Much better	93%
Little better	4
Worse	1
Same or don't know	2

Compiled by National Opinion Research Center

per cent said most doctors fail to tell the patient things he ought to know, but only 11 per cent said this about their own doctors.

The chief complaints against personal physicians (percentages in parenthesis): Appointments inconvenient (31), not enough personal interest (21), charge too much (17), don't give chance to tell trouble (15), suggest unnecessary visits (14), give better care to regular patients (13), fail to tell patients what they ought to know (11) and more interested in money (10).

As might be expected, medical economics figured heavily in the complaints. Thus, excessive charges, undue interest in money, unnecessary visits, giving unnecessary medicine and working too fast were emphasized, especially when the profession as a whole was considered. In this case, the answers given to questions about the relative effectiveness of private physicians were interesting.

Most Use Private Doctors

Some 61 per cent of the group, for example, said they considered that the care provided by salaried doctors is about the same as that provided by private physicians. At the same time, however, 75 per cent said they usually consulted a private physician rather than a private or public clinic or hospital. And they considered him as good as, or better than, other doctors.

Some 93 per cent of the polled citizens said today's medicines are "much better" than those of 30 years ago. And the majority, 63 to 89 per cent, said doctors could help in cases of allergy, arthritis, asthma, diabetes, heart disease, hypertension and sinus. Only a minority, however, believed that they could help in gallbladder trouble, kidney disease, piles or varicose veins.

On the issue of whether a scientifically selected sample of the general population would be willing to submit to medical examinations to help verify interview health surveys, the National Opinion Research Center said seven out of ten persons questioned said they would be willing. The most frequent reason given for agreeing was a desire to help the Government in its research efforts. However, the degree of follow-through on intention still remains to be tested by actual field trial. ■

HOW ASEPTIC IS THE DENTIST'S INJECTION?

Survey finds much improvement in recent years, though technique deficiencies remain

When a dentist injects a local anesthetic, how aseptic is his technique? To find out, a DDS from the University of Miami medical school has surveyed sterilization procedures employed by over 600 Florida dentists. The group, says Dr. Doran D. Zinner, includes graduates of every U. S. dental school and, thus, "probably reflects dental practices in other areas. His results:

More dentists than ever are using autoclaves for sterilizing needles and syringes; only a small minority now split an anesthetic cartridge between two or more patients; a majority, however, still do not routinely disinfect the oral mucosa prior to injection.

The findings, the Miami dentist explains, mirror the dental profession's response to an intensive, five-year educational campaign. In 1956, Dr. Zinner conducted a similar survey showing that "the methods then in use for sterilization of needles, syringes and cartridges were unsatisfactory, prior preparation of the oral mucosa was inadequate" and cartridges were often re-used.

As corrective measures, he recommended an educational campaign by professional organizations, use of disposable needles for individual injections, and a complete halt to the practice of re-using partially-consumed cartridges.

The American Dental Association supported the idea and launched a drive to alert the profession to the dangers of oral infection. National and state dental journals actively called for improvement; dental-supply manufacturers cooperated by placing disposable needles on the market.

Dr. Zinner's new survey indicates that the proportion of dentists who autoclave needles and syringes has jumped from approximately 30 to nearly 50 per cent. The use of boiling or "cold sterilization" (soaking in antiseptic solutions) has fallen off, though many dentists employ the latter technique for aseptic storage of autoclaved instruments.

More than 30 per cent have entirely sidestepped the needle-sterilization problem by using disposable needles; another ten per cent do so occasionally. Comments Dr. Zinner: "Here is an area of marked progress; five years ago, very few dentists used disposable needles."

The greatest improvement — and perhaps the most crucial — concerns re-use of anesthetic cartridges. As a result of the ADA campaign, Dr. Zinner finds that less than one dentist in ten now employs this risky procedure; in 1956 the figure approached one in three.

His findings on oral asepsis before injection are less encouraging. The proportion of dentists employing topical disinfectants routinely has actually fallen slightly, from 43 to 38 per cent; another eight per cent disinfect occasionally. The remainder, says Dr. Zinner, "either are unaware of the potential hazard, do not believe that the oral mucosa can be sterilized," or feel that topical anesthetics (routinely employed by 72 per cent of dentists) produce adequate asepsis. ■

STERILIZATION TECHNIQUES OF SURVEYED DENTISTS

METHOD	NEEDLES	SYRINGES	CARTRIDGES
Alcohol Wipe	under 1%	1%	14%
Alcohol Soak	under 1	2	30
Antiseptic Soak	13	27	23
Autoclaving	48	48	2
Boiling	19	20	1
Flaming	under 1	0	under 1
Hot Air	under 1	under 1	1
Other	17	under 1	under 1
None	under 1	under 1	28

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Dexamethasone	0.75 mg.

Although the incidence of significant side-effects is low, the usual contraindications to corticosteroid therapy apply to Haldrone.

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TRANSILLUMINATING light with 500 watt bulb is used to locate and visualize fluid secretions and other abnormal pathology.

BRAIN LESIONS SPOTTED WITH LIGHT

Transillumination of the skull becomes a simple, safe and useful tool for early differentiation of intracranial pathology

Every child at some time holds his hand to a strong light and views with fascination the shadows of the bones through the translucent flesh.

Turning this child's play to use in diagnosis of the child, two Seattle clinicians have improved and extended the technique of skull transillumination to the point where it "can now be removed from the category of medical curiosity and be considered a useful diagnostic tool."

With transillumination, Dr. David B. Shurtleff of the University of Washington's department of pediatrics, and Ada M. Cambern, director of photography at Children's Orthopedic Hospital, Seattle, are able to detect asymptomatic lesions in the neopallium of infants with normal or enlarged skulls. For the past four years they have also used the "safe and easy" technique to detect subdural and extracerebral fluid collections.

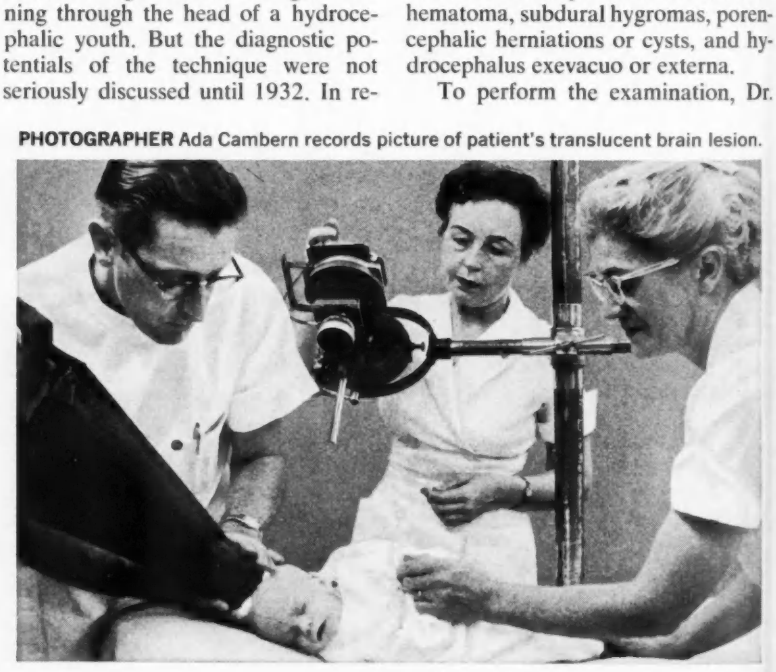
"The simplicity of the procedure encourages early diagnosis before pressure distorts the brain irreparably," they report. "Such early diagnosis is essential for effective surgery. Transillumination may obviate more elaborate diagnostic measures and afford a basis for prognosis."

The medical possibilities of the method have been known since the 19th century, when English physician Richard Bright noticed sunlight shinning through the head of a hydrocephalic youth. But the diagnostic potentials of the technique were not seriously discussed until 1932. In recent years transillumination has been successfully used to visualize hydranencephaly, internal hydrocephalus, cysts of the fourth ventricle, postmeningitic subdural effusions and subacute hematomas.

Now the Washington investigators have developed and extended the procedure to encompass chronic subdural hematoma, subdural hygromas, porencephalic herniations or cysts, and hydrocephalus exevacuo or externa.

To perform the examination, Dr.

PHOTOGRAPHER Ada Cambern records picture of patient's translucent brain lesion.



Shurtleff lightly places an ordinary flashlight against the infant's head. The light beam, he says, must be directed at right angles to the skull and over all areas in order not to overlook any local lesions.

Having thus located and visualized the fluid secretions, the Seattle group photographs them with the help of a 500 watt spotlight.

Because of the relatively long time exposures needed—in some instances as much as four minutes—the patient must be held as immobile as possible. (Dr. Shurtleff finds it useful to sedate the patient heavily.) The skull is then carefully explored with the flashlight to find the best position for the spotlight. The powerful beam is narrowed by an opaque black cone to produce a two-inch aperture encircled by a ring of black rubber, which prevents any stray light from escaping into the examining room. A distance of 18 inches between the lamp and the child's head will prevent a possible burn, says Mrs. Cambern.

Case Histories Cited

The transillumination photographs shown on these pages were made with two lights. One provides the beam for the illumination of the lesion, the other is a supplementary light with a very short exposure on the lower part of the face, producing a subdued facial image which makes orientation much easier.

Some previously puzzling factors in abnormal cranial configuration have been illuminated by some of the individual cases observed by the Seattle group. For example:

▶ A differential diagnosis between internal hydrocephalus and subdural hematoma in a three-month-old male patient megacephalic since birth. Physical examination revealed only a symmetrically enlarged cranium which, under transillumination, suggested a right subdural fluid collection. This was later confirmed by pneumoencephalography. At craniotomy, a filmy membrane enclosing a clear fluid was found, and after surgery the area of transillumination gradually diminished.

Despite the relatively short follow-up period, suggests Dr. Shurtleff, this case shows that when severe internal hydrocephalus occurs in association with extracerebral fluid collections, it may not carry the poor prognosis of this condition when it is found by itself.

▶ A porencephalic cyst communicating with the right ventricle in a six-week-old male hospitalized with Salmonella meningitis. The infection was eradicated with difficulty and the child recovered slowly. Repeat subdural punctures were negative. Although the ventricles were only slightly enlarged, studies showed 160 mm of CSF pressure and rapid progression of hydrocephalus with herniation of the right ventricle. The area over the herniation transilluminated in a pattern similar to the defect. After decompression with a Heyer valve, the abnormal translucence slowly disappeared.

This case is an example, says Dr. Shurtleff, of the demonstration of a local brain defect by transillumination; in addition it illustrates the origin of some porencephalic cysts.

▶ A two-day-old male with an enlarged head, possessing no suck reflex, a very weak Moro reflex and minimal response to noxious stimuli. The fontanelles were bulging and the posterior half of the infant's head—45 cm in circumference—transilluminated. The patient, who was diagnosed as suffering from advanced internal hydrocephalus, died 17 days after birth. Postmortem studies showed the cerebral mantle was thicker in some areas than in others, despite generalized intraventricular pressure.

The limit of light transmission in this case was about the middle of the head, where the brain was approximately one cm thick. In seven other children with hydrocephalus, the Seattle pediatrician adds, the greatest thinning occurred in the frontal, temporal or parietal areas. In each instance the brightness of the transmitted light faded gradually at the margins of the defect, in contrast with the sharp borders seen in extracerebral fluid collections.

Blood Cells Block Light

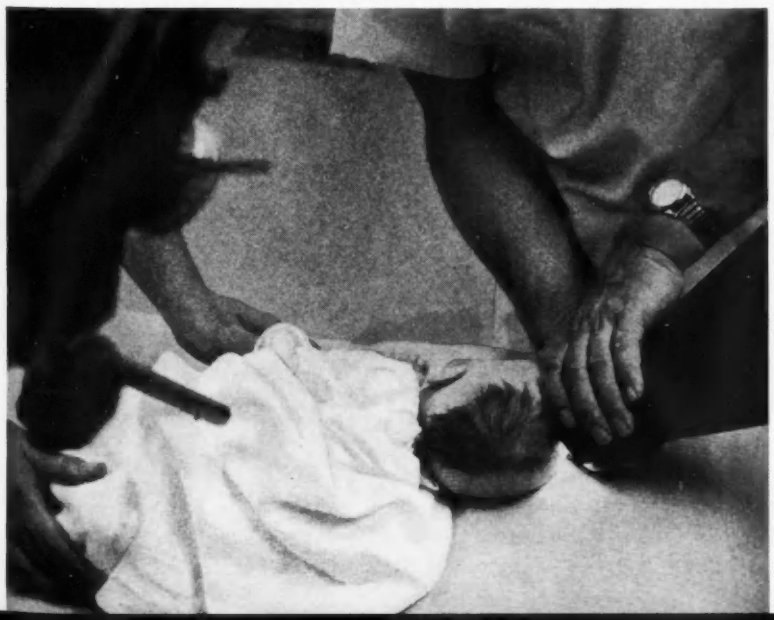
The brightness of the light transmitted, in Dr. Shurtleff's experience, seems to be more directly related to the depth of the overlying tissue than to the nature of the fluid itself, except when the fluid contained a high proportion of red blood cells.

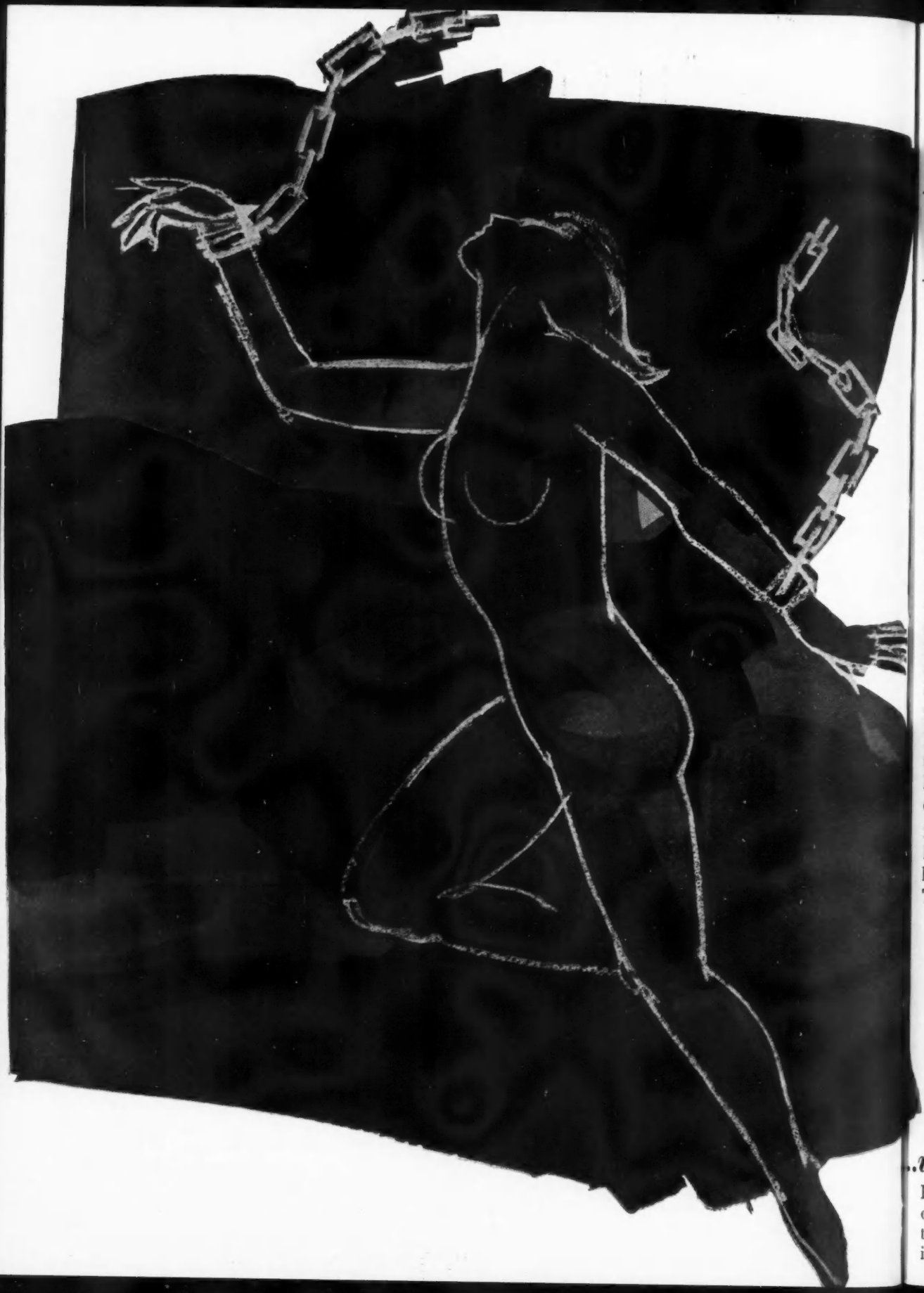
"It thus appears," he continues, "that a high-protein, darkly xanthochromic fluid will allow the diffusion of light. Measurements of pathological material and x-rays indicate that a total thickness of brain and overlying tissue greater than two cm will prevent the passage of light. Apparently one cm of brain tissue is a limiting factor, and aging thickens the skull and scalp so as to impede light transmission, even in the absence of cerebral mantle.

"Certainly, however, the contribution of age to density of skull and scalp does not always prevent transillumination, even in some microcephalic and normocephalic subjects.

"Routine transillumination of the heads of all children having abnormal cranial configurations, or showing evidence of neurological disease or developmental retardation involving the cranium, is important," the Seattle researchers stress. ■

CONE with rubber ring enables pediatricians to focus all the light on infant's head.





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1. Correction of menstrual dysfunction. *Cyclic* therapy with ENOVID controls dysfunctional uterine bleeding (menorrhagia, metrorrhagia) and often establishes a normal menstrual cycle in amenorrhea.

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5. Endocrine infertility. ENOVID has been used successfully in *cyclic* therapy of endocrine infertility, promoting subsequent pregnancy through a probable "rebound" phenomenon.

6. Endometriosis. *Continuous* therapy with ENOVID corrects endometriosis by producing a pseudodecidual reaction with subsequent absorption of aberrant endometrial tissue.

The basic dosage

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From the beginning, woman has been a vassal to the temporal demands—and frequently the aberrations—of the cyclic mechanism of her reproductive system. Now, to a degree heretofore unknown, she is permitted normalization, enhancement, or suspension of cyclic function and procreative potential. This new physiologic control is symbolized in an illustration borrowed from ancient Greek mythology—Andromeda freed from her chains.

MD DILEMMA: TO TELL, OR NOT TO TELL

The physician who is asked to reveal confidential material about a patient faces a touchy legal problem. Though 'medical privilege' is traditional, not all states recognize it

When an investigator knocks on a physician's door and requests information about a patient, what are the physician's rights and duties? What can he do ethically—and what must he do legally?

These thorny questions in the complex realm of privileged communications are being examined again as a result of the defection to the Soviet Union of two National Security Agency employees, Vernon F. Mitchell and William H. Martin.

Twenty-four hours after the first published account of their disappearance, NSA investigators were rapping on the Silver Spring, Md., door of Mitchell's psychiatrist, Dr. Clarence Schilt. Within weeks, Dr. Schilt was subpoenaed by the House Un-American Activities Committee and was testifying behind closed doors. (No evidence was made public as to whether Dr. Schilt testified willingly or under pressure.)

While Dr. Schilt refused to divulge his testimony to the press, the substance of his statement leaked out. It appeared that Mitchell had visited the psychiatrist three times earlier in the year. He had discussed homosexuality, family problems and religion, but had given no indication at all of disloyalty.

In the wake of these disclosures, it didn't take long for a heated controversy to develop. Thirty-seven Washington-area physicians responded with a petition to Maryland's Medical and Chirurgical Faculty asking for an investigation of a "possible breach of medical ethics" in the case. "Information given to a physician within the doctor-patient relationship," they declared, "must be considered confidential and must not be disclosed except with the permission of the patient or under certain well-defined criminal circumstances."

A District of Columbia psychiatrist said that nine out of ten of his colleagues in the Washington area were up in arms about the case, primarily because of the "profound reaction" among their patients who include many Government employees.

"I don't think there was a patient who came into an office that week who wasn't terribly shaken," he told MEDICAL WORLD NEWS. If a patient says he has secrets about missiles which he's going to take to Moscow, no one would question the psychiatrist's duty to take action to protect the national security; it would be similar to a patient saying he intended to commit suicide or murder, where the physician must face the obligation of protecting the individual and society. But in this case, the psychiatrist had no data about national defense or any other criminal matter."

The Council of the Washington Psychiatric Society felt it necessary to issue a public statement characterizing the Schilt testimony as a breach of the principle of confidentiality which "may have given rise to apprehension in the minds of psychiatric patients or those contemplating such treatment. Our Council wishes to reassert this principle as binding upon physicians and to deplore departure from this principle. Without the assurance of confidentiality, medical treatment, and especially psychiatric treatment, would be impossible."

Nor was the reaction confined to the capitol. When the story was published in Los Angeles, Dr. Murray Abowitz stated, "Many patients raised the question about the security of the material that they were confiding in me. I assured them, with full sincerity, that I would sooner go to jail than violate their confidence."

Unethical or Patriotic?

But other voices were raised in Dr. Schilt's defense. Dr. John R. Cavanagh, (see *Editorial,* p. 48) a consultant to a number of Government agencies, told a Civil Service Commission seminar that the psychiatrist had committed no breach of ethics. "Such a revelation is not likely in any way to harm the physician-patient relationship except possibly on the part of potential traitors who are, thank God, quite rare in this country," the Washington specialist added.

John Loy, the executive secretary of the Montgomery County (Md.) Medical Society, backed Dr. Schilt's

TIPS A DOCTOR SHOULD KEEP IN MIND CONCERNING THE PROBLEM OF 'CONFIDENTIALITY'

- The right of privileged communication, in those states which have laws granting it, belongs to the patient and not to the doctor. Under it, a patient may prevent his doctor from testifying about his medical treatment and the information the doctor receives during the treatment (see chart).
- Only 33 states and the District of Columbia have enacted statutes providing privileged communication in the doctor-patient relationship and many of these states have limited or questionable statutes. Physicians are advised to check the law in their state carefully in order to know their legal rights—and their patients'.
- Where the privilege exists, it usually can be waived only by the patient. A doctor who discloses confidential information without the express permission of the patient may be liable for damages.
- Where there is no law granting privilege, the problem extends to the patient's medical records, including the doctor's notes, memos, appointment books, financial records, etc. Because all records may be subpoenaed, warns the Group for the Advancement of Psychiatry, a doctor "must prepare them in such a way that they will not introduce distortions. This calls for mature and considered judgment . . . and irrelevant confidential material should be systematically excluded."
- Even where privileged communication is sanctioned by law, other statutes may require a doctor to report to the authorities evidence of crimes, like gunshot wounds and abortions, and infectious diseases, such as venereal diseases and typhoid fever.

conduct as that of any patriotic citizen. The Professional Conduct Committee of the Maryland Medical and Chirurgical Faculty ruled that the psychiatrist acted in an ethical manner; that no law was violated (Maryland has no statute on privileged communication for doctors); and that the national interest "transcends that of the individual." The Committee's action was criticized sharply by Dr. Victor W. Sidel of Bethesda in a comprehensive review of the problem of confidentiality in the *New England Journal of Medicine* (MWN, July 21).

In his own defense, Dr. Schilt said he felt that Mitchell's defection fell within the "well-defined criminal circumstances" cited by his critics as exceptions to the confidentiality rule. "Furthermore," he added, "if the national security is threatened, I believe the rights of the Government far exceed the rights of individuals." When two patients queried him after the newspaper article appeared, he said, "I told them they had nothing to worry about as long as they didn't defect."

Whatever may be the ultimate professional assessment of Dr. Schilt's actions, the incident clearly shows that the legal and ethical requirements surrounding the doctor-patient relationship are not as simple as popularly supposed. Most laymen—and some physicians, perhaps—believe the doctor-patient privilege is similar to the privileged relationship existing between attorneys and clients. The reality is that the doctor-patient relationship is much less clearly defined and protected.

The right of privilege was first granted to physicians in a New York statute enacted in 1828. Its rationale was summed up in 1876 by the N.Y. Court of Appeals which held that the desirability to society of facilitating medical treatment outweighed the social benefits that might be derived from compelling doctors to reveal information. "To open the door to the disclosure of secrets revealed on the sick bed, or when consulting a physician," the Court said, "would destroy confidence between the physician and the patient, and, it is easy to see, might tend very much to prevent the advantages and benefits which flow from this confidential relationship."

In recent years, some prosecutors and lawmakers have attacked the priv-

CONTINUED ON PAGE 34

STATE LAWS GOVERNING PRIVILEGED COMMUNICATIONS BETWEEN PHYSICIAN AND PATIENT

Typical Statute: "A Physician or Surgeon shall not, against the objection of his patient, be examined in a civil action or proceeding, as to any information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient."

Laws in 33 states and District of Columbia generally follow this pattern in both civil and criminal codes. Exceptions are noted below.

STATE	INCLUSIONS	EXCEPTIONS
ALASKA	Physicians, surgeons	(typical statute)
ARIZONA	Physicians, surgeons	**D**
ARKANSAS	Physicians, surgeons, nurses	**E**
CALIFORNIA	Physicians, surgeons	**F, G, H**
COLORADO	Physicians, surgeons	**G**
D of C	Physicians, surgeons	Criminal cases, **C, F**
HAWAII	Physicians, surgeons	**D, G**
IDAHO	Physicians, surgeons	(typical statute)
INDIANA	Physicians only	(typical statute)
IOWA	Physicians, surgeons, nurses, attendants	(typical statute)
KANSAS	Physicians, surgeons	**D**
KENTUCKY	Physicians only	(typical statute)
LOUISIANA	Physicians only	**J**
MICHIGAN	Physicians, surgeons	**G, H**
MINNESOTA	Physicians, surgeons	**H**
MISSISSIPPI	Physicians, surgeons	**C, H**
MISSOURI	Physicians, surgeons	(typical statute)
MONTANA	Physicians, surgeons	(typical statute)
NEBRASKA	Physicians, surgeons	**D, H**
NEVADA	Physicians, surgeons	**G, H**
NEW MEXICO	Physicians, surgeons, nurses	**A, D**
NEW YORK	Physicians, surgeons, nurses	**H, I**
NORTH CAROLINA	Physicians, surgeons	**K**
NORTH DAKOTA	Physicians, surgeons	**D**
OHIO	Physicians only	**D, H**
OKLAHOMA	Physicians, surgeons	**D**
OREGON	Physicians, surgeons	**D**
PENNSYLVANIA	Physicians, surgeons	**B**
SOUTH DAKOTA	Physicians, surgeons	**D**
UTAH	Physicians, surgeons	(typical statute)
WASHINGTON	Physicians, surgeons	(typical statute)
WEST VIRGINIA	Physicians, surgeons	(typical statute)
WISCONSIN	Physicians, surgeons	Homicide, **F, G, H**
WYOMING	Physicians only	**D**

EXCEPTIONS

A Includes only MDs knowledge of "venereal or loathsome diseases."
B Only covers data tending "to blacken the character" of the patient.
C MD need not testify on **any** information about patient without consent.
D If patient testifies on any "privileged" matter, privacy is waived.
E Permission to testify granted to one medical attendant applies to all.
F MD may testify on mental competency of patient without consent.
G MD may testify in malpractice or other suits brought against him.
H Upon death of patient, consent is required of executors, heirs, etc.
I MD may testify if patient is possible victim of a crime.
J Court-appointed MDs **must** testify.
K A judge of a superior court may compel disclosure if "in his opinion it is necessary to the administration of justice."

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OFFICIAL BROCHURE

SPARTASE is a mixture of equal amounts of the potassium and magnesium salts of aspartic acid. Pharmacological and clinical observations have been made which indicate that SPARTASE participates in intermediary metabolism in such a fashion as to be effective therapeutically in the management of fatigue.

General Pharmacological Properties—The IP and PO LD_{50} values for SPARTASE in rats are 4 and 19 grams/kg., respectively.

The pharmacological activity of aspartic acid has been the subject of numerous publications[1-8] and need not be reviewed.

Laborit *et al.*[9,10] studied the effects of the combined K and Mg aspartates on groups of white rats subjected to the standard swim test. It was found that duration of swim after this therapy was significantly prolonged over that achieved with other regimens attempted. After a standard rest period of 2½ hours, the aspartate-treated animals again swam longer than any other group.

Plasma ammonia levels were measured in groups of rats similarly exposed to swim effort and drug therapy. Increase in ammonia levels noted in the controls[11] was not seen in the group pretreated with the aspartates.

A group of 16 dogs breathing a mixture of 90% oxygen and 10% CO_2 was given the combined salts of aspartic acid parenterally. Plasma and expired CO_2 tension decreased, and plasma urea concentration increased immediately[12].

The administration of K and Mg aspartates to athletes demonstrated a positive effect on neuro-muscular irritability, a significant reduction in existing fatigue and a significant prophylactic effect against the induction of fatigue[10,13,14].

Indications—The use of SPARTASE for the treatment of fatigue is not intended to supplant specific treatment for accompanying organic disease or to substitute for specific indications for potassium.

SPARTASE has a wide range of clinical utility in the management of the fatigue syndrome. It may be used effectively in the management of many fatigue problems, whether or not associated with functional or organic disease. SPARTASE is particularly useful in treating the tired patient with no evidence of organic dysfunction.

Dosage and Administration—The adult dose of SPARTASE is two 500 mg. tablets after the morning and evening meals. Approximately four days therapy are required before subjective clinical improvement may be noted; it is suggested that SPARTASE administration be continued for at least two weeks before the patient is re-evaluated.

Contraindications and Side Effects—Nausea, abdominal discomfort and diarrhea have been noted occasionally. These symptoms may be minimized by proper administration of dose after meals.

There are no known contraindications to SPARTASE therapy.

References—1. H. Kamin, P. Handler: J. Biol. Chem. *193*:873-80 (1951). 2. H. Resnik, M.F. Mason: Am. J. Med. Sci. *192*:520-5 (1936). 3. J.A. Brockman, Jr., S.L. Burson, Jr.: Proc. Soc. Exptl. Biol. Med. *94*:450-2 (1957). 4. H.H. Tallan: J. Biol. Chem. *224*:41-5 (1957). 5. B.J. Miller, V.W. Ciacci, S.P. Reimann: Growth *5*:329-50 (1941). 6. S. Edlbacher, K. Schmid: Helv. Chim. Acta *28*: 1079-88 (1945). 7. D.P. Tschudy, M. Marshall, A. Graff, S. Graff: Cancer *11*:984-95 (1958). 8. M.N. Mickelson, R.S. Flippin: Arch. Biochem. Biophys. *64*:246-8 (1956). 9. H. Laborit, R. Moynier, A. Trzebski, G. Guiot, C. Baron: Compt. rend. soc. biol. *151*:1383-6 (1957). 10. C. Vial: Imprimerie des Tournelles, Paris, 1959. 11. H. Laborit, L. Obrenovitch, P. LeGuen: Compt. rend. soc. biol. *152*:1359-60 (1958). 12. H. Laborit, P. Niaussat, J.M. Jouany, B. Weber, J. Martin, C. Baron: Compt. rend. soc. biol. *152*:1094-7 (1958). 13. Thiebault: Bull. mens. soc. med. mil. franc. *52*:139-49 (1958). 14. H. Laborit, B. Weber, P. Niaussat, J.M. Jouany, G. Guiot, J. Zawadowski, C. Baron: Anesthésie et analgésie *15*:480-94 (1958).

ilege on the ground that it obstructs justice by withholding important information from investigators, judges and juries.

Against this challenge many physicians and medical societies have strongly reasserted the necessity of confidentiality to assure successful therapy.

For example, the Committee on Psychiatry and Law of the Group for the Advancement of Psychiatry, opposing the obstruction-to-justice theory, has declared:

"It is difficult for this Committee to conceive that the interests of society and justice will be better served by weakening the force of the confidential relationship.... It is our belief that the social value which effective psychiatric treatment has for the community far outweighs the potential loss of evidence resulting from the withholding of testimony...."

The Committee proposed a model statute which would place the confidential relationship between physician and patient on the same legal basis as between attorney and client.

Partly as a result of the Schilt case, the American Psychiatric Association and other medical organizations have attempted to define the physician's rights and obligations.

In general these statements affirm the need for confidentiality. In general, also, few physicians would question the doctor's duty to obey specific laws which require him to report evidence of specific crimes, such as gunshot wounds. Nor would many doctors challenge a physician's right to act to prevent a crime of violence which a patient announced he intended to commit—whether the doctor's action was to hospitalize the patient or inform the family or the police.

Much less clear-cut, however, are such situations as a demand by investigators for any and all information about a patient, where the doctor has no information of a criminal nature. And confusion is not confined to the law enforcement aspects of the problem. Confidentiality may be breached in the handling of medical records within a hospital, in the manner in which a case is presented to staff conferences and in research and writing on medical problems. ■

ABSTINENCE expert, Dr. Borje Ejrup (l.), checks physical condition of an ex-smoker.

NICOTINE 'THERAPY' HELPS END SMOKING

Swedish clinician combines alkaloid injections with psychotherapy to break tobacco habit

To help smokers give up cigarettes, a non-smoking Swedish doctor uses tobacco therapy. He injects patients with a tobacco alkaloid, either nicotine or lobeline hydrochloride. And for those who begin to crave candy after giving up cigarettes, he has non-fattening sucking tablets containing a little nicotine.

The aim, at first, is to sate the patient with such a large dose of the injectable alkaloid that smoking a single cigarette makes him nauseous. When this happens the withdrawal process has begun, claims Dr. Borje Ejrup, associate professor at the Karolinska Institute, Stockholm.

In a ten-day period, he injects up to a total of 200 mg nicotine or 800 mg lobeline, depending on individual sensitivity. Two or three injections may be necessary on the very first day, because just one puff sets off the habit, he says. Some patients may also need an anticholinergic to relieve hunger pangs. Others get tranquilizers to alleviate "irritation."

Heart-to-heart psychotherapeutic talks with the patient are a necessary part of the treatment. This helps him eliminate the idea of smoking and avoid relapses, which Dr. Ejrup says are due in most cases to psychological stresses.

The result of treating 4,000 cigarette smokers in the last five years has been an increase in the abstinence rate from 65 to 88 per cent. This includes patients who have smoked heavily for the past 30 years. Those unable to break the habit have at least cut down their rate of consumption from 25 to 75 per cent, he adds.

Patients come to Dr. Ejrup's four "Tobacco Withdrawal Clinics" in Stockholm for a variety of reasons. They feel that cigarette smoking has something to do with their cardiovascular ailments, chronic bronchitis, fatigue or similar conditions, he explains. They do not mention fear of cancer and rarely the expense of cigarettes, which cost 75 cents a pack in Sweden. Most smoke about 20 cigarettes daily, and some as many as 50.

He finds that the patient's age and the number of years of smoking cigarettes appear to be unimportant in determining the success of withdrawal. Those over 60 stop smoking as easily as younger patients, and those with a 30-year history of cigarette smoking give up the habit as readily as those with a ten-year history.

Heavy smokers have the greatest difficulty in abstaining because they have to make radical changes in their way of life, Dr. Ejrup points out. But when they do, "they frequently say they had felt themselves slaves to an obsession, and the majority are surprised to discover how little pleasure smoking had actually given them." ■

'YES' AND 'NO' ON SOCIAL SECURITY

Delegates to the National Medical Association meeting follow the AMA on care of the aged, but they assert an opposing view on Social Security coverage of self-employed MDs

Some 1,700 Negro physicians, meeting in New York, agreed to go along with the AMA on two issues, but they split sharply with the Association on a third. They rejected the King-Anderson bill and Senator Kefauver's drug marketing proposals, but enthusiastically endorsed Social Security coverage for doctors.

The 66th annual convention of the National Medical Association was dominated by a single issue: King-Anderson vs Kerr-Mills—the Administration's proposed Social Security bill vs the state-administered law. It not only roused the greatest delegate interest, but got the close attention of two medical association presidents.

Marking the first time that an AMA president has appeared before the 5,000-member NMA, Dr. Leonard W. Larson put the case against King-Anderson on a professional-to-professional level.

"I appeal to you as doctors of medicine," said Dr. Larson. "Base your evaluation of this Government-controlled program on your ability to render quality care."

Dr. Vaughan C. Mason, the NMA's incoming president, questioned King-Anderson economics. "It's fantastic to talk about expanding a program that is already running in the red. This bill is unwanted, unnecessary and unworkable," he told his colleagues.

DELEGATE Mazique holds minority view.

Before the issue was brought to a vote, however, the NMA's House of Delegates listened attentively as past-president Dr. Edward Mazique of Washington, D. C., urged support of the Administration proposal:

"The King-Anderson bill can open hospital doors from which we [Negroes] have long been barred, both in the North and in the South."

Dr. Mazique was warmly applauded, even though many NMA members privately doubt that the proposed Federal legislation would particularly help Negro MDs to obtain hospital privileges in some areas.

Resolution Differs Considerably

When a state-by-state vote was finally taken, the tally was 171 votes for Kerr-Mills, 44 against. Only Arkansas, the District of Columbia, Mississippi and North Carolina failed to endorse existing Kerr-Mills machinery.

"But our resolution differs considerably from the AMA's" said retiring president, James T. Aldrich, of St. Louis.

In an interview with MEDICAL WORLD NEWS, Dr. Aldrich pointed out that "the NMA resolution doesn't say a single word about socialized medicine." He also drew attention to the section urging NMA members "to work for fair and equal distribution of Kerr-Mills aid to the Negro aged in those states that historically discriminate to the disadvantage of the Negro."

There was no debate or dissent, however, when the House took up the matter of Social Security coverage for doctors. Bypassing Dr. Mason's comment that such coverage is "not a pension plan but a compulsory tax," the reference committee urged adoption of its report for four reasons:

Most Americans are covered by Social Security. Why not doctors?

Doctors contribute to the fund indirectly through the built-in cost of products and services.

Doctors contribute directly through their employment of business and domestic help.

Social Security benefits provide a base for retirement income.

The delegates agreed these reasons were sound and approved "inclusion of self-employed physicians under Social Security" by unanimous vote.

By a similar vote, they agreed to the adoption of a resolution stating that "only physicians can judge the efficacy of drugs." Thus, they joined with the AMA in disapproval of Senator Kefauver's proposed regulations on new drugs—particularly the section giving the Government the power to decide whether a drug is of value in treating human ills.

DRS. ALDRICH and Larson confer.

As the four-day convention drew to a close, NMA president Mason disclosed that he hopes to "strengthen" the AMA-NMA liaison committee.

"It has been in existence since the mid-1940s," he said, "but has been largely a paper organization up until the present time."

Dr. Mason, chief of obstetrics and gynecology at New York's Sydenham Hospital, then pointed to a particular area he thinks needs investigation.

"The AMA's medical disciplinary committee has just come out with a fine report urging action against unethical doctors. Now, I say that discrimination is unethical, too. Maybe our liaison committee can nudge some of the AMA's local societies into giving this a little thought." ■

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a more clinically useful diuretic/antihypertensive

IN BRIEF

RENESE (polythiazide) is a new, highly potent, orally effective, nonmercurial diuretic, saluretic, and antihypertensive agent with a high therapeutic index, low order of toxicity, and an intrinsically prolonged duration of action which enhances the excretion of sodium and chloride by the renal tubules.

INDICATIONS: RENESE is indicated for the treatment of hypertension and edema. It has been found useful in congestive heart failure, fluid retention of pregnancy, premenstrual tension, obesity (where fluid retention is present), renal edema, cirrhosis, drug-induced edema, and toxemia of pregnancy.

ADMINISTRATION AND DOSAGE: *Initial dose:* Depending on the severity of the conditions, initial doses of RENESE may range from 1 mg. to 4 mg. daily (refractory cases may require as much as 12 mg. daily). *Maintenance dose:* Usual effective maintenance doses range from 1 mg. to 4 mg. daily, depending on the severity of the cases. Some patients have responded to 1 mg. every other day (0.5 mg. daily).

SIDE EFFECTS AND PRECAUTIONS: Since all diuretic agents may reduce serum levels of sodium, chloride, and potassium, patients on RENESE should be observed regularly for early signs of fluid or electrolyte imbalance. Caution must be exercised during digitalis administration to prevent hypokalemia since patients are then more sensitive to the development of digitalis toxicity. During RENESE therapy of edema in patients with chronic renal disease, routine precautions should be taken against renal failure as indicated by an increasing blood urea nitrogen. Like other thiazide diuretics, RENESE may cause a rise in serum uric acid levels and should therefore be used with caution in patients with gout. Should overt manifestations of gout appear, the concomitant use of uricosuric agents may be effective in relieving the symptoms. Side effects with RENESE, such as nausea, vertigo, weakness, and fatigue are infrequent and seldom require cessation of therapy. Most of these reactions may be overcome by reducing the dose of RENESE or by taking measures to improve any electrolyte imbalance. Mild maculopapular skin rash has been rarely reported. Extra precautions may be necessary in patients who may require norepinephrine, or curare or its derivatives.

SUPPLIED: RENESE is available as 1 mg., white, scored tablets in bottles of 30; 2 mg., yellow, scored tablets in bottles of 30; 4 mg., white, scored tablets in bottles of 30.

More detailed professional information available on request.

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1 mg. 2 mg. 4 mg.

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DIURETIC/ANTIHYPERTENSIVE

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dosage dexterity
dependable diuresis
enhanced effectiveness
foremost flexibility
increased individualization
long lasting
marked micturition
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peak potency
prolonged performance
reliable response
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unsurpassed utility
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"prolonged performance"

– RENESE activity lasts for at least 24 hours on a single dose[1] – thus assuring convenient once-a-day dosage for most patients, every-other-day dosage for selected patients. With RENESE available as 1 mg., 2 mg., and 4 mg. scored tablets, there is a once-a-day form for *each* and *every* patient – mild, moderate, or severe.

1. Ford, R. V.: Current Therap. Res. 3:320, July, 1961.

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THE LAB GOES TO THE PATIENT

A self-contained trailer unit speeds a nationwide study of the rheumatoid diseases

A far-ranging mobile laboratory of the National Institute of Arthritis and Metabolic Diseases is carrying basic research in rheumatoid pathologies from town to town. Operated by Dr. Thomas A. Burch, the 22-foot trailer has visited nearly every state of the union, as part of a nationwide epidemiological study of Sjogren's syndrome.

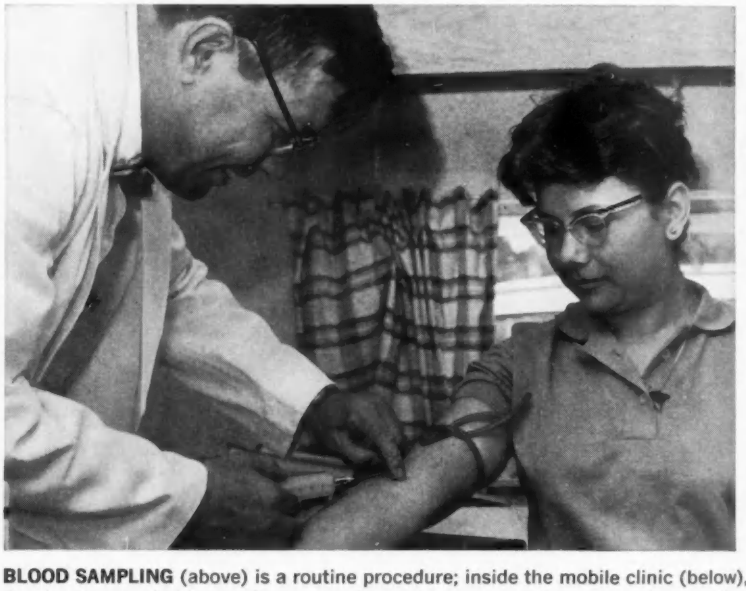
Investigation of this apparently familial disease, often associated with rheumatoid arthritis, may clarify understanding of the entire rheumatic disease complex, Dr. Burch believes.

In his compact little clinic—which also serves as his "home" en route—the NIAMD investigator performs physical examinations, blood tests, roentgenographs and other procedures. The vehicle hauling the trailer has a 3,000-watt generator to power the x-ray equipment; a lead lining in the trailer closet provides radiation protection for unexposed x-ray film. A ten-vial centrifuge rests on the sink drainboard, which doubles as a laboratory bench.

Dr. Burch's study involves examination both of Sjogren's syndrome patients and their relatives. Control studies are then done on normal neighbors of the same age, sex and race. On any given day, Dr. Burch may interview and examine from two to 15 individuals. Abnormal findings are reported, on the patient's request, to his own physician.

Next on Dr. Burch's agenda is a study on the prevalence of arthritis in different climates. The first such survey, which will get under way this month, will cover the Blackfeet Indian Reservation in Montana. ■

ISOLATED SETTLEMENTS are frequent stopping-places for trailer laboratory. Epidemiological study of rheumatoid patients is taking it to nearly every state.



BLOOD SAMPLING (above) is a routine procedure; inside the mobile clinic (below), Dr. Burch spends his evenings preparing specimens, packing exposed x-ray film.

Editor's Choice

Abstracts of articles concurrent with publication in leading specialty journals

CLUE TO NATURAL CANCER IS FOUND IN HUMAN EXPERIMENTS

Why do circulating cancer cells become implanted and metastasize in some patients and not in others? Several preliminary observations suggest that the concentration of circulating cells is an important factor.

On the assumption that autotransplantation of cancer cells would serve as a model of natural metastases, 35 patients with advanced cancer were given subcutaneous injections of their own cancer cells. Most also received one or two trocar implants of cancer tissue fragments and homotransplants of human H.Ep.-3 cells. Five were considered to be cases of successful autotransplantation after nodules appeared at the site of cell injection. Of the four in whom autotransplants grew, two also had prolonged growth of the H.Ep.-3 homotransplants. In the other two, autotransplant nodules were slow to appear and homotransplants regressed. In seven other subjects, autotransplants failed to grow and homotransplants were rejected.

These data, although meager, suggest a correlation between homotransplant and autotransplant growth. Homotransplants of neoplastic cells grow better in terminal cancer patients. There also seems to be a direct relationship between advanced stages of cancer and autotransplantability of cancer cells.

No growth appeared at any site inoculated with less than a million cells.

Since a large number of cells is required to establish an implant under experimental conditions, this may also be the case in spontaneous metastases. It seems possible that in both experimental and spontaneous metastases, the multiplication of smaller numbers of viable cancer cells is, in some manner, restrained or prevented by the host. *Southam and Brunschwig; Cancer, Sept.-Oct. 1961, pp. 971-78.*

FATE OF ALKYLATING AGENTS TRACED IN CANCER PATIENTS

The metabolic fate of three anticancer agents, *TEM, TEPA* and *Myleran,* has now been determined in humans. Radioactive tracer techniques, used to plot blood levels, disappearance rates and urinary excretion rates of the alkylating agents in patients with malignant tumors, reveal that all three agents appear to follow a similar metabolic pattern — rapid disappearance from the blood and almost total excretion in the urine within 24 hours. Maximum blood levels are reached within five minutes after injection, however, and within two hours after oral administration. Blood levels then drop precipitously to one to three per cent and remain at this value over the next 48 hours. Approximately 30 per cent of the drugs is excreted unaltered in the urine.

Proliferative tissue apparently has a selectivity for *Myleran* and *TEM.* Biopsies of enlarged lymph nodes and surrounding skin and muscle taken 24 hours after administration showed insignificant amounts of these drugs in skin and muscle while measurable amounts of *TEPA* appeared in muscle.

The usual therapeutic doses of these alkylating agents produce the same palliative response in cancer patients whether given by the oral or the intravenous route. Massive or repeated doses only increase toxicity without increasing blood levels. *Nadkarni, Trams and Smith; Cancer, Sept.-Oct. 1961, pp. 953-56.*

INFANTS SHOULD BE VACCINATED BEFORE THE THIRD MONTH

There is strong evidence that infants vaccinated early in life are capable of antibody response and that immunization begun before the sixth to eighth day of life is effective.

For one thing, most gamma globulin is antibody, and the concentration of gamma globulin in full-term infants is comparable to that in adults. It also seems that the absence of isohemagglutinins—the "natural antibodies"—before the third month of life results from a "delayed" stimulus to the cells that produce them, rather than from an inability to produce them.

Antibody response in babies injected with diphtheria vaccine between the sixth and tenth day, for example, is as good as in those injected at six weeks. Antibody response against pertussis has also been noted among vaccinated two-week olds. Pertussis immunization at an early age is especially desirable because mortality from this disease is highest in infancy and passively acquired maternal antibody affords negligible protection.

On the other hand, transmission of antibodies against polio from mother to offspring does occur and can interfere with active immunization. It is noteworthy, however, that oral polio vaccine appears to be less influenced by acquired maternal antibody than the injectable form.

The convenience of the triple vaccine supports its continued use, although diphtheria and tetanus in infancy do not pose as great a threat as pertussis. And it is probably better not to vaccinate against smallpox at an early age because of the risk of vaccinia gangrenosum in agammaglobulinemic infants. *Pearlman; AMA Arch. Dis. Child., Aug. 1961, pp. 114-23.*

CONTACT LENSES CAN BE FITTED IN ROUTINE OFFICE PRACTICE

Corneal contact lenses are quite successful in the majority of cases. Ophthalmologists who refuse to fit them are losing patients to optometrists.

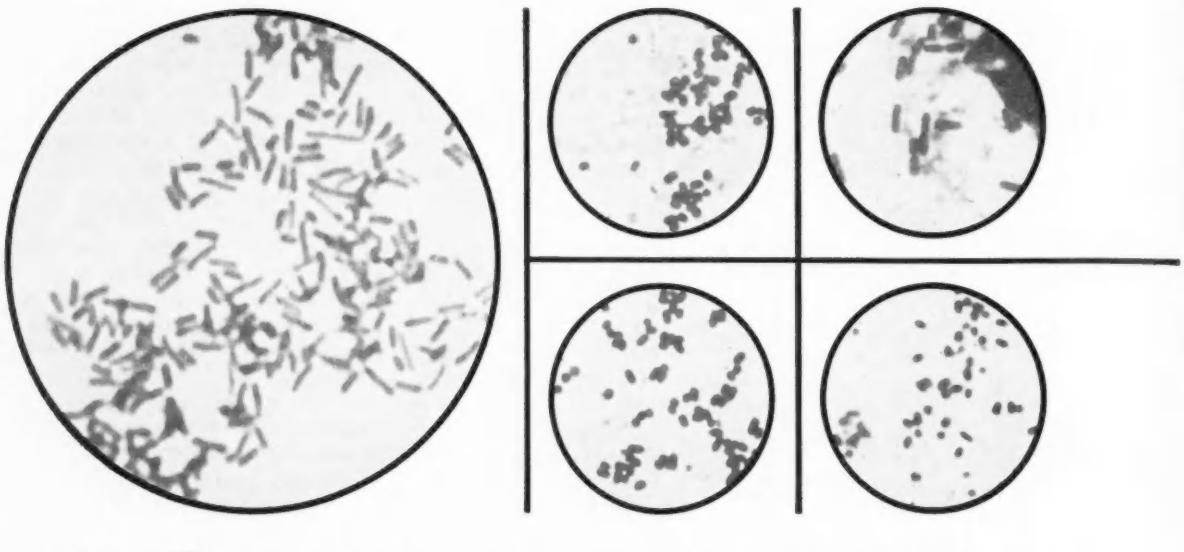
Fitting begins with a refraction and keratometer reading rather than by using trial lenses, except in cases of keratoconus. The lenses, which come in a variety of sizes, are ordered from a manufacturer. Patients should wear them for only five hours on the first day. This should be increased by half an hour a day until the lenses can be kept in place for ten to 12 hours. Patients need to be warned, of course, of the possibility of corneal abrasions and the remote chance of permanent scarring. But with care these complications rarely occur.

In the early stage, lens adjustments are frequently necessary. Usually, the width of the peripheral curve has to be increased. This loosens the lens and increases wearing time. After adapting to the lenses, the patient may need the peripheral width adjusted further to relieve the feeling of "tightness"—blurring, fogging, foreign body sensation.

Myopia, hyperopia, astigmatism, keratoconus and, especially, aphakia respond well to contact lenses. Aphakic patients experience improved peripheral vision and less image distortion. *Cassady; AMA Arch. Ophthal., Aug. 1961, pp. 89-94.*

ANNOUNCING

a new antibiotic for gram-negative infections...
especially those caused by Pseudomonas



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THE ONLY BRAND OF COLISTIMETHATE SODIUM

COLY-MYCIN IS PARTICULARLY VALUABLE IN ACUTE OR RESISTANT GRAM-NEGATIVE URINARY INFECTIONS. It is "the drug of choice"[5,15] in many urinary infections due to Pseudomonas. Coly-Mycin has also been of value in respiratory, blood stream, surgical, wound and burn infections when due to sensitive organisms. It is often successful when other antibacterials fail.[1-5]

FOR EXAMPLE: In one study, Coly-Mycin cleared the urinary tract of Pseudomonas infection in 58 of 60 patients. In another study, "Fifteen of the 18 patients infected with *Escherichia coli* who were treated with colistin [Coly-Mycin] had sterile urine cultures upon conclusion of treatment."[13]

PRIMARILY BACTERICIDAL[1,6,8,10] Unusually effective against a wide range of gram-negative pathogenic bacteria, especially *Pseudomonas aeruginosa, Escherichia coli, Aerobacter aerogenes* and *Klebsiella pneumoniae.*[1-15] (Not effective against Proteus.)

RAPIDLY EFFECTIVE Therapeutic blood levels[1,6,8,10,11] and urine concentrations are quickly attained.[5,8]

EXCEPTIONALLY WELL TOLERATED in patients of all ages at recommended dosage. No blood dyscrasia, renal damage, eighth nerve disturbance or other serious reaction has been reported, but minor side effects—such as circumoral paresthesias, pruritus, vertigo, and drug fever—have occurred.

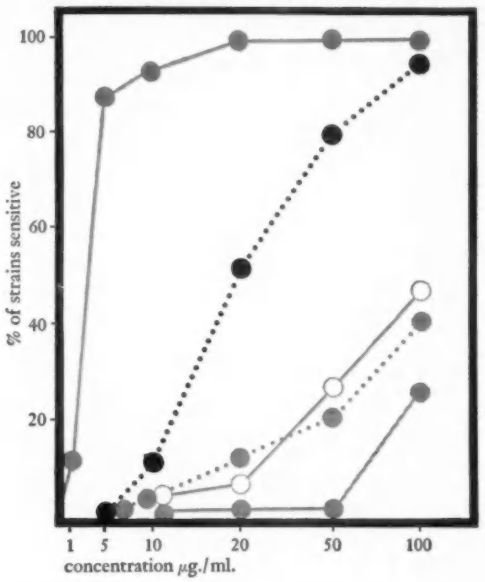
- To date there have been no reports of monilial overgrowth due to Coly-Mycin therapy.
- Resistant strains develop infrequently.[1,6,10]
- No cross resistance to broad-spectrum antibiotics has been reported,[6] however, cross resistance to polymyxin does occur.

Full dosage information, available on request, should be consulted before initiating therapy.

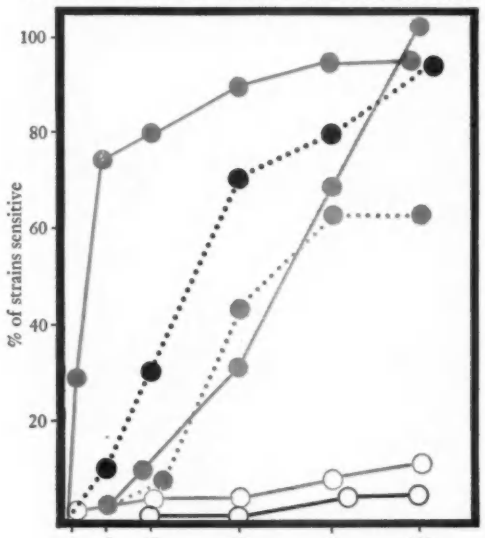
Supplied: in vials containing 150 mg. colistimethate sodium and 8 mg. dibucaine hydrochloride for reconstitution with 2 ml. sterile distilled water for injection. *For intramuscular injection only.*

References: 1. Carroll, G., and Malette, W. F.: J. Urol. *85*:86, 1961. 2. Petersdorf, R. G., and Hook, E. W.: Bull. Johns Hopkins Hosp. *107*:133, 1960. 3. Hall, J. W.: Am. J. M. Sc. *240*:561, 1960. 4. Zinsser, H. H.; Lattimer, J. K., and Seneca, H.: J. Urol. *83*:755, 1960. 5. Roberts, C. E., Jr., and Kirby, W. M. M.: Colistin in the treatment of hospitalized patients with Pseudomonas infections, presented at the 1960 Conference on Anti-Microbial Agents, Washington, D. C. 6. Schwartz, B. S., *et al.*: Antibiotics Annual 1959-1960, New York, Antibiotica, Inc., 1960, pp. 41-60. 7. Graber, C. D.; Tumbusch, W. T., and Vogel, E. H., Jr.: *Ibid.*, pp. 77-79. 8. Wright, W. W., and Welch, H.: *Ibid.*, pp. 61-74. 9. Ross, S.; Puig, J. R., and Zaremba, E. A.: *Ibid.*, pp. 89-100. 10. McCabe, W. R.; Jackson, G. G., and Kozij, V. M.: *Ibid.*, pp. 80-88. 11. Blaustein, A.: *Ibid.*, pp. 75-76. 12. Meleney, F. L., and Prout, G. R.: Surg. Gynec. & Obst. *112*:211, 1961. 13. McCabe, W. R., and Jackson, G. G.: Am. J. M. Sc. *240*:754, 1960. 14. Carroll, G.: J. Oklahoma M. A. *53*:678, 1960. 15. Seneca, H.; Lattimer, J. K., and Zinsser, H.: New York J. Med. *60*:3630, 1960.

BACTERICIDAL ACTIVITY OF COLY-MYCIN AND 4 OTHER ANTIBIOTICS AGAINST PSEUDOMONAS*



BACTERICIDAL ACTIVITY OF COLY-MYCIN AND 5 OTHER ANTIBIOTICS AGAINST ESCHERICHIA COLI*



*Adapted from Petersdorf and Hook.[2]

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DOCTOR'S BUSINESS

Since Britain launched the National Health Service 13 years ago, the country's biggest private health plan has continued to grow. The British United Provident Association reports its membership stands now at 850,000, up from 65,000 in 1948. Members pay about $10 million a year for the privilege of receiving private treatment and private hospital accommodations denied under the state scheme.

Doctors looking for houses can now apply for mortgage loans of up to $26,500 for a period of 30 years. The new regulations apply to Federal-chartered savings and loan associations. Up until now, the maximum amount of home mortgage loans was set at $22,000 for a 25-year period.

Switching from one type of life insurance to another is rarely a good idea, warns the National Association of Insurance Commissioners. Doctors are often urged by insurance agents to replace an old policy in favor of something "more modern." This can create problems. Says the Association: "it is rarely to the best interest of a policyholder to surrender or lapse an existing policy of permanent life insurance and replace it with new life insurance." The major reasons are the possible loss of disability benefits and annuity incomes, loss of money put into the original policy, and the payment of additional commissions and charges. The Association advises policyholders to "insist upon a written proposal comparing relative benefits under the two policies."

The doctor draft, already being stepped up, is getting a reappraisal by Defense Department officials. With draft calls scheduled to double almost immediately, volunteer enlistments by physicians may fall short of estimated needs. As a result, additional doctors may be called up. Initial draftees will serve with Army and Navy units. Doctors in the Reserve will also be vulnerable if Kennedy obtains authorization to call up to 250,000 reservists between now and next July 1.

The donor who waits too long to make a family gift may be adding to the taxes his heirs will eventually have to pay. A Federal Tax Court has made this point in reviewing the case of a woman who built a house for her son and promised that one day it would be his. For 30 years, however, she failed to carry out her promise. And not until shortly before her death did she finally sign a deed of transfer. The Government taxed the property as an inheritance rather than a gift, claiming the transfer had been made "in contemplation of death." The son appealed the decision but the Tax Court upheld the Government's original conclusion in the case.

With the Keogh bill still awaiting Congressional decision, many states are going ahead with Keogh-like measures of their own. Florida has become the ninth state to provide professional people the same tax advantages already given to corporations. Other states in which this is now a legal procedure: Arkansas, Connecticut, Georgia, Illinois, Ohio, South Dakota, Texas and Tennessee. Similar measures are now pending before the legislatures of Alabama, Oklahoma and Pennsylvania.

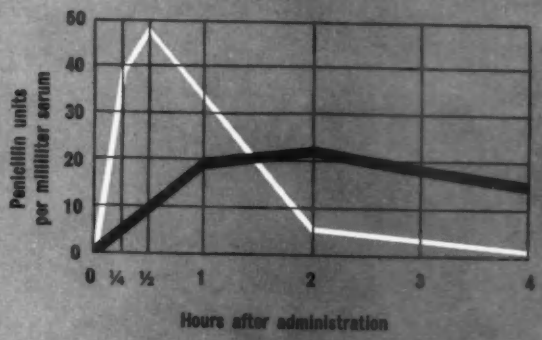
More state and Federal tax offices are exchanging information on errors and adjustments in individuals' income tax returns. The tax sleuths also swap notes on estate and gift tax returns. People who file late returns, fail to file state returns, make excessive refund claims, etc., are also vulnerable to this joint state-Federal effort to tighten up law enforcement. So far, nine states are involved in the exchange: Utah, California, Kansas, Wisconsin, North Carolina, Kentucky, Colorado, Minnesota and Montana. Others are on the verge of signing up.

Manufacturers of dictating machines report a sharp rise in sales to physicians who are using the devices for recording histories and dictating their observations after major procedures. And pharmacists now are making recordings of calls from doctors who phone in prescriptions. Industry sources predict that sales should climb to about $95 million this year, compared to some $85 million in 1960. Biggest U.S. producer is the Dictaphone Corporation which makes 60 per cent of the machines produced here and sells 35 per cent of all units marketed in this country. Other major producers: SoundScriber, Edison Voicewriter and IBM.

A potent oral penicillin for high therapeutic efficacy

You can prescribe PEN•VEE K for any and all infections caused by penicillin-susceptible organisms. It is a reliable and predictable antibiotic. Demonstrable blood levels occur within 15 minutes after ingestion: peak blood levels within 30 minutes. PEN•VEE K is markedly effective for treatment and prophylaxis of common bacterial infections, including hemolytic streptococcal infections, certain staphylococcal infections, and pneumococcal and gonococcal infections.

Serum concentrations— oral and parenteral penicillin



⊖ Potassium penicillin V, 250 mg. (400,000 units)—one tablet. Average of 40 fasting subjects.[1]

Procaine penicillin G (600,000 units)—one injection. Average of 10 subjects.[2]

Palatable, convenient, well tolerated

PEN•VEE K is palatable, convenient (tablet or liquid), and well tolerated. These factors encourage good patient cooperation, which helps promote rapid recovery.

References: 1. Peck, F.B., Jr., and Griffith, R.S.: Antibiotics Annual 1957-58, Medical Encyclopedia, Inc., p. 1004. 2. White, A.C., et al.: Antibiotics Annual 1955-56, Medical Encyclopedia, Inc., p. 490.

For further information on limitations, administration, and prescribing of PEN•VEE K, see descriptive literature or current Direction Circular.

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Letters to the Editor

Large Race, Small Race

Your item entitled "Aspirate Test Discloses Chronic Amebiasis," (MWN, June 23) interested me greatly.

The value of this procedure relative to stool examinations is, of course, a controversial subject. However, the statement attributed to Dr. Shlaes to the effect that the stools almost never show the large race of Entamoeba histolytica, certainly does not conform to well established facts. I also think it is unlikely that he claimed to have discovered the existence of large and small races.

HOWARD B. SHOOKHOFF, M.D.
Division of Tropical Diseases
Department of Health
New York, N. Y.

[Dr. Shookhoff is quite right. We erred in suggesting that Dr. Shlaes discovered the large and small races in Entamoeba histolytica. It's been known for 100 years or more that there are two races. Dr. Shlaes was accurately quoted, however, in saying that in his study at Cook County Hospital in Chicago, large race amoebae were seldom found in stools of patients with low grade chronic amebiasis. In over 65 per cent of the 290 cases reported, only small race amoebae were found in the stools, whereas large race were recovered from the bowel wall in over 90 per cent.—ED.]

'Tis Gray

I would like to call your attention to an error in "Tis Neither Black Nor White" (MWN, Aug. 4).

You made the statement that the Medical Disciplinary Committee report urged that "the AMA be given 'original jurisdiction' to suspend or revoke the license of an individual member — whether or not any action has been taken against him at the local level."

It is the prerogative of the states to grant, suspend or revoke a license to practice medicine. No state medical association, nor the AMA, wishes to usurp the prerogative of the state government.

Actually the Committee recommended that the AMA be given original jurisdiction "to suspend or revoke the *AMA membership* of a physician guilty of violating the Principles of Medical Ethics or the ethical policy of the Association. . . ."

EDWIN J. HOLMAN
Secretary
Judicial Council
American Medical Association
Chicago, Ill.

Illinois Solons

A recent issue (MWN, June 23, "Where Your Congressmen Stand on Federal Care for the Aged") contained an article in which the Democratic Senator from Illinois, [Sen. Paul Douglas] expressed his position that the Federal Government should provide health care for all our older citizens through Social Security.

The Republican Senator [Everett M. Dirksen] declined to give his position.

I wrote to Sen. Dirksen and requested that he give me a definite answer regarding his position on this important matter. He informed me that he is opposed to the inclusion of a compulsory medical care plan for the aged under Social Security.

Since Sen. Dirksen's views have generally coincided with those of organized medicine, I thought you would like to know how Sen. Dirksen stands.

B. B. NEUCHILLER, M.D.
Woodstock, Ill.

Names in the News

Col. R. P. Mason, a physician and epidemiologist and director of the Walter Reed Army Institute since 1956, has been named vice president for research by the American Cancer Society.

Dr. Joseph E. Ghory, assistant clinical professor of pediatrics at the University of Cincinnati College of Medicine, has been appointed medical director of the Convalescent Hospital for Children, Cincinnati.

Dr. William H. Feldman, chief of laboratory research in pulmonary diseases for the Veterans Administration, has been elected an honorary member of the Section of Comparative Medicine of the Royal Society of Medicine, London. Dr. Feldman is widely known for his pioneering work in the use of drugs for the treatment of TB.

The Illinois State Medical Society presented special commendations to the research team that has developed a promising vaccine for viral hepatitis. The recipients are: **Dr. Joseph D. Boggs,** associate professor of pathology, Northwestern University Medical School; **Dr. I. William McLean, Jr.,** assistant director of microbiological research, Parke, Davis & Company; and **Dr. Wilton A. Rightsel,** senior research scientist for Parke-Davis.

President-elect of the American Neurological Association is **Dr. Charles D. Aring,** professor of neurology and director of the department in the University of Cincinnati College of Medicine. He will succeed **Dr. James O'Leary,** professor of neurology at the Washington University School of Medicine, St. Louis.

Dr. Vaughan Carrington Mason, chief of obstetrics and gynecology at Sydenham Hospital, New York, was installed as president of the National Medical Association during its 1961 convention in New York City. An outstanding sprinter on the University of Pennsylvania track team, he earned his MD degree at Toronto's McGill University and has earned distinction in the field of gynecology and obstetrics.

Dr. Calvin F. Kay, associate professor of medicine at the University of Pennsylvania School of Medicine, is director of a new cardiovascular research center to be established in the Hospital of the University. Made possible by a $1.9 million grant, the center will make special facilities available for research on diseases of the heart and blood vessels.

Dr. Edward A. Adelberg, member of the editorial board of the *Journal of Bacteriology* and consultant to Lilly Research Laboratories, named chairman of Yale's microbiology department.

Dr. John A. D. Cooper was named dean of the University of Miami School of Medicine. The 42-year-old physician, associate dean of Northwestern University Medical School, has done extensive work in the fields of metabolism and radiobiology and is a consultant to the Atomic Energy Commission.

Dr. Alan Thal, former associate professor of surgery at the University of Minnesota, assumed the duties of chairman of the department of surgery at Wayne State University's College of Medicine on Aug. 1.

Drs. Felicien Ilunga and **Marcel Tshibamba** of the Congo were the first in their own country to graduate as medical doctors. By 1963, it is expected that 60 more doctors will graduate from the University of Lovanium, Leopoldville, with the assistance of the World Health Organization.

Dr. Henry van Zile Hyde, assistant to the Surgeon General for International Health and chief of the Division of International Health, U. S. Public Health Service has been chosen by the Association of American Medical Colleges to head its new division of international medical education.

OBITUARIES

Dr. Robert Dax, 73, a founder of the American Hospital in the Paris suburb of Neuilly; in Neuilly, Aug. 8.

Dr. Norman Jolliffe, 59, internationally known nutritionist and, since 1949, director of New York City's Bureau of Nutrition; in his continuous concern with overweight he dramatized the problem by coining the word "appestat," a composite of "appetite" and "stat," to describe an appetite-regulating mechanism; he also linked the U. S.'s high coronary rate with its high-fat diet and, through clinics and his literary output on the subject, made the world cholesterol-conscious; though blind and restricted to a wheel chair since 1959, he remained at his job until a week before his death; from complications of diabetes; Aug. 3, in New York City.

Dr. Gustav Nylin, 68, leading Swedish cardiologist, widely known for his research on cardiac and vascular diseases, he was former president of the Inter-European Society of Cardiology; Aug. 6, in Stockholm.

Dr. John D. Kernan, 84, professor emeritus of rhino-otolaryngology at the College of Physicians and Surgeons, Columbia University, where he had taught for 50 years; a member of the Harvard varsity crew of 1899, he subsequently joined Admiral Peary's expedition to the North Pole and, on his return, he became the first Roman Catholic accepted for internship at New York's Presbyterian Hospital; July 21, in New York.

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ASPECTS OF DEATH

Morris Fishbein, M.D.

No one has ever died who was ready to die. ARISTOPHANES

The belief prevails that certain people have a predilection for death. An unusual study of the subject has been made by two Harvard Medical School psychiatrists, Drs. Avery D. Weisman and Thomas P. Hackett. In a recent report in *Psychosomatic Medicine,* they call attention to a group of patients who, without open conflict, suicidal intention, profound depression or extreme panic, correctly anticipated their own deaths.

They note that all but a few human beings have some fear of dying. An even greater fear—far more than fear of death—however, is the dread of impairment from illness. "Extinction," they say, "is less feared than is the prospect of progressive dissolution. In this period, the physician, especially the psychiatrist, can extend his care and help his dying patient to achieve an appropriate emotional world in which to die."

Give Dignity to Death

Drs. Weisman and Hackett believe that the physician can reconcile the dying patient to his death by replacing the image of being an abandoned dead body with the prospect of "the dignified death of a significant individual."

Regrettably, new techniques in medical care often detract from the dignity of death. One sees patients with a tube in the mouth, another in the nostrils, an oxygen tent over the head, a vessel dripping solutions into the veins, perhaps other tubes evacuating excretions, and the eyes looking askance at visitors who peer with agonized expressions through the surrounding plastic.

Dr. John R. Cavanagh, a psychiatrist at the Catholic University Medical Center, Washington, D. C., in a talk before a group of hospital chaplains (MWN, June 9) said: "It is my conviction that when death is inevitable, when the dying process is beyond doubt, the patient should be allowed to die unencumbered by useless apparatus."

All psychiatrists agree that the psychotherapy of dying patients is a difficult and challenging professional problem. Much more study, they believe, must be focused on death than has ever been given to it in the past. One physician noted recently the extraordinary reluctance of modern medical society to deal with the theme of death, and he is convinced that this applies notably to physicians who frankly avoid even mentioning the word "death" outright. He observes particularly how "the phenomenon of death and its various aspects are hidden or blurred by an embarrassed reluctance or pained look of curiosity in its presence, or by institutionalizing death in hospitals, in homes for the aged, and finally by the mortician's efforts at achieving a 'new look' by remolding the face, rouging the skin, and other manipulations in a macabre form of postmortem rehabilitation."

The Harvard psychiatrists' unusual scientific study of dying concludes: "Instead of viewing death as a failure beyond his competence, the physician can extend his care and help his dying patient to achieve an appropriate emotional world in which to die."

If from such studies as this, anxieties can be allayed, fears ablated and a greater understanding achieved by the living in their relationships to those who are dying, much good will have been accomplished.

Morris Fishbein